**State of Utah**

JON M. HUNTSMAN, JR.
*Governor*

GARY R. HERBERT
*Lieutenant Governor*

**Department of Human Services**

LISA-MICHELE CHURCH
*Executive Director*

Division of Services for People with Disabilities

GEORGE KELNER PH.D.
*Director*

Dear Employer,

Welcome to Self-Administered Services, a service option available through the Division of Service for People with Disabilities (DSPD). This option allows you to become the employer and to hire, train, and schedule your employees for some or all of your services. By choosing to become an employer you are expected to follow certain rules and assume certain responsibilities. Your first responsibility is to read, understand and sign the Service Agreement. This is your contract with DSPD and our documentation that you agree to follow the responsibilities outlined in this Support Book.

This book will teach you about DSPD's mission, values and beliefs, which are the foundation for the supports and services DSPD offers. This book also details the requirements and the specific rules you and your employees need to follow under Self-Administered Services. You will learn how to establish your program; how to hire and train your staff; how to monitor the quality of services you will use; and how to complete the required paperwork.

Please read this Support Book carefully and thoroughly. Also work closely with your Support Coordinator to make sure all your questions are answered and your program complies with DSPD and Medicaid requirements. Becoming an employer can be complicated but with this information and the help of your Support Coordinator you will triumph.

Wishing you great success!

# *Acknowledgements*

This is the fourth edition of the Support Book
that has been updated to conform and meet the
Division of Services for People with Disabilities
requirements. Based on information from a variety
of sources, this edition of the
Self-Administered Service Support Book
retains the best of previous editions
and adds new material to make it more relevant
to the roles and responsibilities of people choosing
to self-administer services.

Acknowledgement and special thanks are extended
to past and current members of the Family Council,
Family to Family Network, Division Staff and
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knowledge, writing and editing of this book.


# Support Book
## 2007

State of Utah
Department of Human Services
Division of Services for People with Disabilities

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# SECTION 1
# Guiding Principles of Self-Determination

## Purpose

This section is designed to help you understand the governing values and beliefs of the Division of Services for People with Disabilities (DSPD) and the expectation that these values be included in all areas of providing supports and services for people receiving services through the DSPD.

## This Section Includes:

- The MISSION of the Division of Services for People with Disabilities (DSPD)

- The Philosophy and Values of Self-Determination including:

    - Natural Supports
    - Self-Sufficiency
    - Safety

# Our Mission

## Is to promote opportunities and provide supports for persons with disabilities to lead self-determined lives.

**Values**

- We respect and support personal choice and personal responsibility
- We respect personal and cultural diversity
- We value the preservation of family and other natural supports
- We believe in stewardship and wise use of public resources
- We value coordination and cooperation
- We believe people deserve high quality supports and services
- We believe funding should be needs based and should follow the person

**We will:**

- Promote and recognize excellence
- Continue a person-centered philosophy
- Promote public awareness of disability issues
- Work collaboratively to dissolve barriers to quality service
- Support a full spectrum of service options
- Support self-determination by assisting persons to exercise and develop their ability to make choices and experience
    a) freedom to make informed choices from among available options of services and supports
    b) authority to control a defined amount of dollars to purchase only what is needed and valued
    c) support to nurture informal relationships that might augment, if not replace, some purchased services, and responsibility to give back to the community.

# PHILOSOPHY AND VALUES OF SELF-DETERMINATION

Self-determination is asserting your right to life, liberty and the pursuit of happiness. It is the freedom and autonomy to date, marry, work, play, and enjoy hobbies. It is the ability to make and spend money, even if sometimes it isn't how others would spend it. It includes accepting and stepping up to responsibilities. Self-determination embraces life; it is about respect, achievements, health and happiness.

## Natural Supports

The concept of natural supports is not something unique to people with disabilities. All people have a need for natural supportive relationships in their lives. These relationships are important to assist in promoting the development of a healthy and happy life. A natural support can be any relationship in a person's life that is unpaid and meaningful. This may include family members, friends, church members, neighbors, co-workers, and other organizational affiliations. A wealth of opportunities is available to people if the time is taken to foster relationships.

## Self-Sufficiency

The ideal outcome when working with people with disabilities is to support people to become as self-sufficient as possible. Some people will not be able to live independently or be able to function without support from their family or paid staff, but when working with people, we should keep in mind the question - what can people do for themselves? Self-sufficiency is about self-esteem, independence, choice making, and most of all individualization. What does the person need and how can the person's strengths help him/her become as successful as possible?

## Safety

Every person has unique abilities and limitations, resulting in unique safety considerations. Safety requirements that are to be incorporated into individual support plans should be based on real, assessed risks, not on speculation, stereotypes, or generalizations about people with disabilities. Additionally, safety issues should be considered within the context of the life desired by the individual.

# SECTION 2
# Medicaid Waiver Services

## Purpose

You will become more familiar with the Division of Services for People with Disabilities, Medicaid rules and regulations and service options available through either self-administering or using agency-based providers. This section begins with a list of commonly used terms and definitions.

## This Section Includes:

- Definition of Terms
- Medicaid Waiver Information
- Service Options Specific to Using Self-Administered Services
- Choosing Appropriate Services
- Home and Community-Based Waiver Service Options

DSPD website: www.dspd.utah.gov. Select Educational Publications/Service Guides for a full overview of DSPD including a list of provider agencies, fiscal agent information for Self-Administered Services and updates.

# DEFINITION OF TERMS

**Action Plan:** A part of the Individual Service Plan (ISP) that identifies personal goals decided upon by a person with a disability and others that support them.

**Agency-Based Provider:** Companies that contract with **DSPD** to deliver supports to people with disabilities.

**Division of Services for People with Disabilities (DSPD):** State agency within the **Department of Human Services,** responsible for administration of State and Federal funding for people with disabilities.

**Eligibility:** Determination of whether or not a person qualifies for services.

**External Support Coordination:** A Support Coordinator outside (not an employee of) DSPD who provides professional support to a person receiving DSPD funding to assist in developing needed services and supports.

**Family to Family Network**: Is a grassroots volunteer group composed of family members across Utah who have a relative with a disability. Their mission is to educated, strengthen, and support families of persons with disabilities.

**Fiscal Agent:** A company that is hired to handle payroll duties for Self-Administered Services, required under Federal Law.

**Guardian:** The person who is legally responsible to/or for the care of another person (and or his or her property).

**Guardianship:** The legal process a parent, family member or other goes through to become legally responsible for a person with disabilities when they are 18 years of age or older.

**Home and Community-Based Waiver:** An approval to "waive" certain requirements in order to use Medicaid funds for an array of home and community-based services as an alternative to institutional care.

**IEP (Individual Education Plan):** Directs the services within a school for a child with a disability.

**Inclusion:** The process of enabling persons with disabilities to be educated, live, work and participate socially in the same environment as others who are not labeled "disabled". Inclusion is also used by educators to refer to the integration of children with disabilities into regular classes for part or all of the school day.

**Informed Consent:** A decision based on knowledge of advantages and disadvantages and implications of choosing a particular course of action.

**Medicaid:** A program that pays health care bills for people who are found eligible for the program. Benefits are paid with Federal and State dollars.

**Medicaid Waiver:** A program used to support people with specific needs to live at home and participate in their communities.

**Monthly Summaries:** A report required at the end of each month given to the Support Coordinator reflecting the use of purchased services.

**Person-Centered Planning Process:** This is an assessment and a process to focus on what a person wants to happen in their life. It identifies interests, goals, relationships, health and safety issues in order to determine appropriate supports.

**Person-Centered Budget:** State and Federal Medicaid funds that are identified to purchase assessed needs of a person being served though the Division of Services for People with Disabilities.

**People First Organizations:** A national organization of people with various disabilities who advocate for the needs of all people with disabilities to be fully included in life experiences.

**People First Language:** Language used that addresses the person first; not the disability.

**Rates:** The amount that DSPD pays to a provider or company for services/supports for a person.

**Self-Administered Services:** A service option for people receiving DSPD funding to manage a variety of identified needed services. This allows a person's supports to be administered by the person/person's representative. It allows the person/person's representative to hire, train, and supervise employees to provide direct supports.

**Self-Determination:** Exercise and development of a person's ability to make their own choices including: freedom to choose their own services and supports, authority to control their own money, ability to nurture natural supports, responsibility to contribute to the community.

**Sib Shop:** Workshops for brothers and sisters of a person who has a disability.

**Support Coordinator:** The professional employee of DSPD who provides support to a person receiving DSPD funding to assist in developing needed services and supports.

**Support Strategies:** The steps used by the employee to support the person to achieve the goals identified in the Action Plan.

**Transition:** Movement from early intervention, to preschool, to elementary school, to middle school, to high school, and to post-school.

**Vocational Rehabilitation:** Preparing a person with a disability for useful and purposeful employment through on-the-job training and use of rehabilitative or adaptive equipment.

# MEDICAID WAIVER INFORMATION

## Medicaid Waivers are Designed to:

- Promote access, inclusion and development of valued social roles in local communities for people with disabilities.
- Foster mutually beneficial relationships among people with disabilities and members of their local community.
- Provide support so that people with disabilities can live safely in neighborhoods they choose.
- Provide support so that children with disabilities can live with their families.
- Improve the independence that people with disabilities have from their caregivers.

## Rules And Regulations

**Avoid Fraud and Misuse of Funds** by following Medicaid Rules and Regulations listed. Individuals who misrepresent the use of Medicaid funds may put self-administering at risk of being lost and face criminal action. Be a responsible employer by working closely with your Support Coordinator and following the DSPD and Medicaid requirements.

- Most Self-Administered Services are to be provided and billed as a one-on-one service. One person to one staff. The **only exception** is Group Respite, services (RP7-RP8), where up to three people may be served.
- Be aware that Supported Living includes more than one support. Do not bill for DTP, CH1, HS1 or PA1 as these services are already included in the Supported Living service description and rate.

Supported Living (SL1) includes: personal assistance, chore and homemaker services, routine transportation

- Stay within the designated pay rates for services, included in the Fiscal Agent Packet.
- **Do Not** bill for more than one person at a time using the same employee, **except** for Group Respite, (RP7-RP8), when up to 3 people may be served.
- Do not receive payment from the employee or take a portion of the employee's pay.
- Employees providing overnight services, during typical hours of sleep, or transportation must be 18 years of age or older.
- Each month the Fiscal Agent (your payroll agency) and your Support Coordinator will review timesheets for accuracy and appropriate usage of services. You may be asked to clarify if the following situations are found:
  - High usage in one month. If a person's situation changes, contact your Support Coordinator and inform him/her of your needs and possible changes in your use of service.
  - High usage of your budget at the end of the fiscal year, (Fiscal Year: July 1 – June 30.) unless approved by your Support Coordinator.
  - Billing for employees before notifying your Support Coordinator. Each Support Coordinator must have a copy in their file of the Form 2-9C, the employee's completed certification. **You must inform your Support Coordinator when adding new employees.**

DSPD is required to account for funds you receive. Examples of misuse of funds have included:

1. Submitting timesheets for an employee who is out of state.
2. Submitting timesheets for an employee who is in prison.
3. Submitting timesheets reflecting more hours than were provided in order to pay an employee at a higher rate.
4. Using service codes that are not in the person's budget. If you need to change services, contact your Support Coordinator to do so. Do not submit timesheets with a code that is not on the Service Plan.
5. Employers receiving a portion of the employees paycheck.

NOTE: If you move from one area of the state of Utah to another, your current budget will move with you. If you move out of state, your services will be closed.

# SERVICE OPTIONS SPECIFIC TO USING SELF-ADMINISTERED SERVICES

The following information provides you with a definition of the Medicaid waivers offered through DSPD. Under each definition you will see a list of services specific to the waiver in which you are enrolled. Agency-based services may be used in combination with Self-Administered Services if needed. All services are based on assessed needs of the person.

**Community Supports Waiver (CSW),** serves people with a diagnosis of mental retardation or related conditions.

| Services | Code |
|---|---|
| Financial Management Services | FMS |
| Chore Services | CH1 |
| Homemaker Service | HS1 |
| Companion Services | CO1 |
| Personal Assistance Service | PA1 |
| Family Training and Preparation | TF1 |
| Supported Living | SL1 |
| Respite | RP1, RP6 |
| Respite-Group | RP7, RP8 |
| Transportation Services | DTP |

**Acquired Brain Injury Waiver (ABI),** serves people with an injury that occurs to the brain after birth.

| Services | Code |
|---|---|
| Chore Services | CH1 |
| Homemaker Services | HS1 |
| Respite | RP1 |
| Supported Living Services | SL1 |
| Transportation Services | DTP |

# CHOOSING APPROPRIATE SERVICES

Your Support Coordinator will provide ongoing supervision to ensure that the needs of your family member being served are identified and met with services selected from an Agency-Based Provider and/or Self-Administered Services.

**Agency-Based Provider Services** are offered through private companies that contract with the Division of Services for People with Disabilities. When using these services, people are able to choose an agency that will meet the specific needs of the person. It is the responsibility of the provider agency to supervise, hire, and assure that employee qualifications are met, including; scheduling, paying wages, etc. of the agency's employees and or supplying other purchased products.

**Self-Administered Services** provide an alternative to traditional agency-based services by allowing you and your family member to directly hire employees to meet specific identified service needs. Most of the time these supports are provided in your home. Self-Administered Services are available to all who are capable and wish to hire and train employees to meet specific assessed needs. You are responsible to supervise, hire, train, schedule, and approve employee timesheets. You must also work with your Fiscal Agent and Support Coordinator to meet DSPD and Medicaid requirements.

**Services Used in Combination.** Your family member may, for example, need respite, personal assistance and to have a ramp built. You can purchase respite and personal assistance through Self-Administered Services or an Agency-Based provider, or respite through Self-Administering and personal assistance through an Agency. Your Support Coordinator can help you to purchase the ramp through available resources. Your budget will reflect how the services are purchased separately.

Regular communication with your Support Coordinator will help to identify service needs for your family member.

# HOME AND COMMUNITY-BASED WAIVER SERVICE OPTIONS

| SELF-ADMINISTERED and AGENCY-BASED SERVICES | **Provider Options** |
|---|---|
| **Financial Management Services:** Fiscal Agents are required under Self-Administered Services. They:<br>(a) process payroll for your employees including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports<br>(b) complete tax forms<br>(c) provide you with a monthly accounting of your budget | Agency-Based Provider Only |
| **Chore and Homemaker Supports:**<br>Chore supports are typically routine and may include:<br>• heavy household chores such as washing floors, windows and walls<br>• snow removal and lawn care<br>• moving heavy items of furniture in order to provide safe access<br>Homemaker supports are typically routine and may include:<br>• meal preparation<br>• laundry<br>• shopping<br>• light housekeeping<br>• routine household care | Self-Administered or Agency-Based |
| **Companion Services** include non-medical personal assistance, supervision, and socialization. Companions may assist the person with meal preparation, laundry, shopping and incidental light-housekeeping tasks. | Self-Administered or Agency-Based |

| | |
|---|---|
| **Personal Assistance** includes assistance with medical and non-medical activities of daily life: supporting basic health care needs, bathing, toileting, dressing, grooming, eating, accessing the community, and incidental housekeeping and chore activities. | Self-Administered or Agency-Based |
| **Family Training and Preparation** includes short-term support to help you understand your role as an employer and to gain necessary skills to self-administer. | Self-Administered or Agency-Based |
| **Respite Care Supports** provide you with short-term relief from your normal care giving. Respite care provides supervision in your own home, an employee's home, an overnight camp, a summer program, or an agency-based facility. Available as a single or group service. | Self-Administered or Agency-Based |
| **Supported Living** includes supervision and training in your own home or in the community, which combines personal assistance, routine transportation, chore and homemaker services. | Self-Administered or Agency-Based |
| **Transportation Supports** provide mileage reimbursement for your employee to support your family member to access the community. | Self-Administered or Agency-Based |
| **Behavior Consultant** includes one-on-one consultation to address behavior problems that your family member may be experiencing. | Agency-Based Only |
| **Day Supports** include daytime support and training for people who need supervision. Day Supports provide a safe, structured setting where people learn skills to participate in and contribute to their community. | Agency-Based Only |

| | |
|---|---|
| **Environmental Accessibility Adaptations** provide equipment, home or vehicle modifications that are needed to keep your family member at home. This may include: ramps, lifts, bathroom modifications, and safety equipment. Discuss specific needs with your Support Coordinator. | Agency-Based Only |
| **Extended Living Supports** provide a temporary replacement service for someone who receives residential services and is sick or on a break from school or day services. | Agency-Based Only |
| **Massage Therapy** is available to someone with a clearly defined medical need and outcome for muscular stress reduction and tension relief. | Agency-Based Only |
| **Personal Budget Assistance** may include assistance to the person with paying bills, writing checks, and balancing a checkbook. | Agency-Based Only |
| **Personal Emergency Response Systems** is a device that enables someone to live independently or with minimal support to summon assistance in an emergency. | Agency-Based Only |
| **Professional Medication Monitoring** is a service provided by a nurse to assess health and safety, ensure that medications are administered as prescribed, and to provide follow-up care. | Agency-Based Only |
| **Residential Habilitation** is a daily residential support for people whose needs can't be met in the family home. | Agency-Based Only |
| **Specialized Medical Equipment, Supplies and Assistive Technology** enables a person to increase his or her ability to perform activities of daily living and to gain greater independence and improved communication. | Agency-Based Only |

| | |
|---|---|
| **Support Coordination** is a required service that assures your family member receives needed services and meets state and federal service requirements. | DSPD-Based or Agency-Based |
| **Supported Employment** provides help to find and maintain full or part-time competitive employment in an integrated setting. | Agency-Based Only |

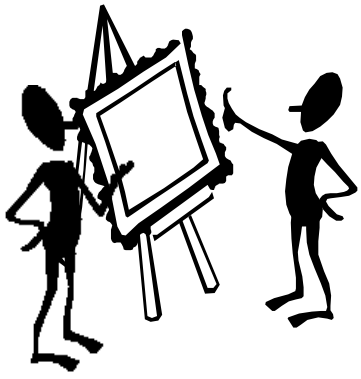
# SECTION 3
# Employer Training and Orientation

## Purpose

This section will help you to set up and monitor your program, hire and train your employee, manage your records and understand your responsibilities as an employer.

## This Section Includes:

- Self-Administered Services Agreement
- Roles and Responsibilities
- Finding and Keeping Employees
- Employer Information for Training and Orientation of Employees
- Home Program Management
- Employer Annual Requirements (Red tab)
- Employer Forms (Orange tab)
- Current Documents (Orange tab)



## Practice Partnering

*"Partnering is aligning with others to achieve a desired result. It is a powerful process for gaining commitment, building loyalty, strengthening retention and leading through collaboration. Successful employers think and talk in terms of "we"; actively sharing information, power, involvement and responsibility for decisions that affect their services."*

Joanne G. Sujansky

# SELF-ADMINISTERED SERVICES AGREEMENT

A service agreement is a binding contract between you and DSPD that allows you to self-administer services. The agreement details your services, budget and responsibilities as an employer. Please read it carefully and discuss any questions with your Support Coordinator.

## When is this Done?

A service agreement will be completed when you decide to become an employer and before setting up a Fiscal Agent. It will be renewed prior to July 1 of each year.

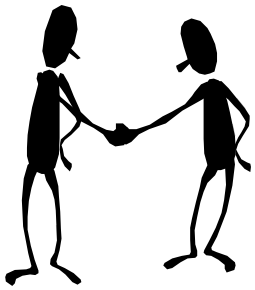
## What Do I Do with the Agreement?

Keep a copy in the Current Documents section (orange tab) of this Support Book. The original service agreement will be kept by the Support Coordinator.

## Can I Cancel my Agreement?

Yes, if self-administering no longer works for you, contact your Support Coordinator and discuss other service options that might work better.

**A copy of the agreement is available in the Employer Forms Section.**



# ROLES AND RESPONSIBILITIES

There are specific roles and responsibilities for each person who supports the success of self-administering services. As the employer, clearly understand each person's role and what you can expect of them.

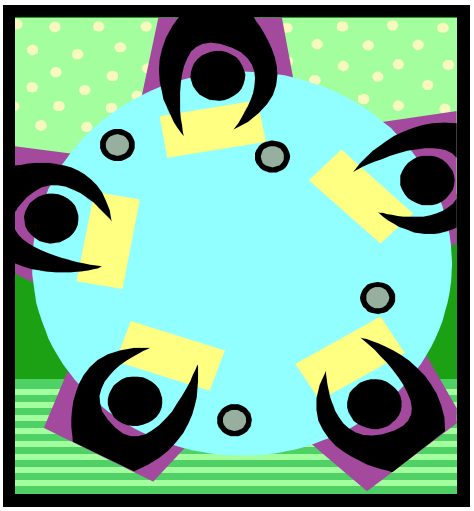
## Who Assumes these Roles?

1. Your Support Coordinator
2. You as the Employer
3. Your Fiscal Agent
4. Your Employees

**Refer to the Role and Responsibilities of each party on the following pages.**

## Are Other People Involved?

Yes, your family member will have a "team". The team may include teachers, other family members, friends, or professionals who can help in planning supports.



# ROLE AND RESPONSIBILITIES OF THE SUPPORT COORDINATOR

**Your Support Coordinator is your primary contact and your link to the Division of Services for People with Disabilities**

## Support Coordinator Responsibilities:

- **Identifies Service Options** - communicates with you to determine and adapt services that will best meet your needs.

- **Implements Person-Centered Planning Processes** - works with you and your family member to identify their interests, preferences and needs in order to develop meaningful supports and goals.

- **Develops an Individual Service Plan** - identifies needed Medicaid services through the Person-Centered Planning process. This includes an Action Plan, which identifies goals to assist you in developing support strategies. Support strategies are outlined steps, which help your employee to know exactly what they are expected to do during their shift.

- **Allocates Funding** - develops an annual budget, makes changes as necessary throughout the year, and monitors the use of funds.

- **Trains on the Use of Self-Administered Services** - defines your responsibilities in managing your program, and helps you become familiar with the Support Book and required forms.

- **Monitors Service** - meets with you at least every three months to get to know your family member and their needs, monitor services for quality and ensures that needs are met.

- **Monitors the Budget** - reviews services and ensures that funds are used as documented on the Action Plan.

- **Monitors Record Keeping** - assists you to meet initial and annual documentation requirements, including the Service Agreement.

- **Refers to Resources** - provides you with information and referral to other agencies that may meet your additional needs.

# YOUR ROLE AND RESPONSIBILITIES AS EMPLOYER

You are responsible to hire, train and manage employees, and ensure that necessary paperwork is completed so your employees are paid.

## Employer Responsibilities:

- Understand your services, review and sign the Service Agreement (form 2-9SA) with your Support Coordinator each year.
- Select a Fiscal Agent from those offered through DSPD.
- Provide current information to your Fiscal Agent of employee status.
- Develop Support Strategies (Employer Forms).
- Establish a Daily File for current records and employee use.
- Maintain your service and employee records for five years.
- Ensure employees meet all training requirements prior to working unsupervised.
- Ensure your employees are 16 years of age or older. If your family member receives overnight or transportation services, your employee must be at least 18 years of age.
- Ensure that all employees complete the required DSPD Background Screening Application (Employer Forms).
- Keep confidential employee files.
- Follow guidelines for submitting Incident Reports (Employer Forms).

- Receive, review and sign timesheets with employees and submit according to the Fiscal Agent's payroll schedule.

- Provide a monthly summary to your Support Coordinator each month by the 15th (Employer Forms).

- Contact the Support Coordinator if there is a need for a change in services or employees.

# ROLE AND RESPONSIBILITIES OF THE FISCAL AGENT

Fiscal Agents process approved employee timesheets and payroll, withhold taxes, and send paychecks to your employees.

## Fiscal Agent Responsibilities:

- Provides you with a packet containing required forms, including forms to hire and pay your employees.
- Provides basic instruction to complete required forms.
- Ensures that required paperwork is received prior to paying your employees.
- Sends paychecks directly to employees and withholds all required taxes.
- Follows set pay periods of no more than two weeks in length.
- Makes payments for services identified on the employee agreement.
- Sends you a monthly report that shows the use and balance of your budget.
- Monitors and maintains current records.
- Discontinues payments to employees who do not pass the DSPD background screening.
- Maintains a customer service call center.

## The Fiscal Agent is not Responsible for:

- Making payments outside the set pay schedule.
- Completing background screening on potential employees.
- Providing workers' compensation.

As an employer you may choose to offer your employees health, life, or workers compensation insurance at your expense. The Fiscal Agent will deduct these premiums at your request.

# ROLE AND RESPONSIBILITIES OF THE EMPLOYEE

Employees provide direct service and supervision to your family member as you have outlined in your Support Strategies. Your employees must become familiar with your family member's specific services and goals and complete all required training.

## Responsibilities of Employees:

- Complete required "Employee Training" found in the Employee Training Section 4, Daily File and Fiscal Agent Packet prior to working with the person unsupervised.
- Provide supports and services that have been outlined on the Support Strategy.
- Complete payroll training including:
    - Filling-out timecards
    - Timesheet comments
    - Knowledge of pay periods
- Behave ethically and follow the Code of Conduct at all times.
- Understand "At-Will" employment, this means that you or your employees may terminate employment without cause or advanced notice. Please make all efforts to work together to resolve any issues. (See page 1, #2 of the Employment Agreement.)
- Notify you immediately if any problems occur with your family member. (See incident report form.)
- Share important information to develop future goals and services.

# FINDING AND KEEPING EMPLOYEES

Hiring and managing employees can be challenging. You may find it helpful or necessary to have more than one employee. This may provide backup when one of your employees is sick or unavailable.

The following information will help you understand basic employment policies and skills needed to find and manage your employees.

- State Employment Requirements
- How to Identify your Ideal Employees
- Where to Advertise
- Screening Prospective Employees by Phone
- How to Conduct a Job Interview
- Hiring and Firing Decisions

# STATE EMPLOYMENT REQUIREMENTS

You should understand the following requirements prior to hiring your employees.

- At-Will employee status applies to all your employees. This allows the employee OR the employer to terminate employment, without notice, for ANY reason (or no reason at all), and results in no disciplinary action.

  (EXCEPTION: Employees/Employers filing neglect, abuse or exploitation complaints must ensure proper procedures are followed. Contact Protective Services and your Support Coordinator)

- Please read the Employment Agreement thoroughly BEFORE signing it with your employee.

**For questions regarding hiring practices in the State of Utah you may contact:**

## Labor Commission of Utah

**Web site:** www.ind-com.state.ut.us
**Telephone:** 1-800-222-1238 - Toll free
(801) 530-6801
(801) 530-7685 (TDD)
**Fax:** (801) 530-7609

**Mailing Address:**
P.O. Box 146630
Salt Lake City, Utah 84114-6630

**Street Address:**
160 E. 300 S. 3rd Floor
Salt Lake City, Utah 84111

## Additional DSPD hiring requirements include:

- You **MAY** hire people 16 years of age or older for all services available using self-administered services. The exception is transportation services and all overnight services (normal hours of sleep) where employees must be 18 years of age. For people 16 years of age or older, but **UNDER** the age of 18, a Parent/Guardian signature is required on the **Employment Agreement**.

- The following **MAY NOT** be employed to work with your family member:

  - Parents
  - Step-Parents
  - Guardians
  - Spouses

# HOW TO IDENTIFY YOUR IDEAL EMPLOYEE

Often the best employees include siblings, cousins, aunts, uncles, grandparents, or other people who know and care about your family member. Often times they may not know how they can help. Think about friends, neighbors, and members of your church community or regular social circles. NETWORK with people you know. They are an excellent resource.

Don't forget current employees. Ask them if they know someone who may be interested in working for you. Always be on the lookout and don't be afraid to ASK people if they would like the opportunity to work for you. If you don't let people know you are looking, you may miss possible employee opportunities.

If family or other people close to you are unable to assist you, your next option is the community at large. Now is the time to advertise.

## Develop a Job Posting

Before contacting employment offices or placing ads (or a job posting) it is important to identify what exactly you need in a prospective employee. It is helpful to generate a list of what the job will include; expected tasks, hours per week, experience required, wage, etc.

## A Possible Wish List May Include:

- Male or female depending on the gender of the client
- Language skills
- Hours available. Specify days, evenings, or weekends
- Ability to safely transfer a **certain** number of pounds
- Familiar with seizure disorders, autism behaviors, etc.
- Familiar with wheelchairs and other assistive equipment

- Assist with daily activities and community outings
- Would like a one-year commitment
- Previous experience

Once you have identified your basic needs and requirements, you can compose a short statement to be printed in the paper or posted on a Workforce Services listing. Be sure to list the items most critical to you in the ad. Keep them simple but specific. The idea is to generate enough interest by a job seeker to at least contact you for a phone interview. If you are having difficulty writing your ad, you can ask the clerk at the newspaper or Workforce Services or your Support Coordinator to help you. List the salary range you are willing to pay, this will keep you from wasting your time on people who may not be interested once they find out the pay range.

## Example of Help Wanted Ads

- **Family Helper Needed.** Outgoing individual needed to assist with therapy/recreational activities for person with disabilities. Needed late afternoon/early evening. Wage range $8 to $10 based on experience or will train. Call 555-5555 for more information.
- **Care Giver Wanted.** Help needed to care for a child with disabilities. Includes feeding, diapering, assisting with self-help skills. Must be able to lift 55 lbs. Must love children. Willing to train right applicant. Contact Mrs. Harriet at 555-5555 for interview.
- **Immediate Opening.** Private employer is seeking a person to assist a young woman with physical disabilities with daily activities on a part-time basis. Some experience preferred. Applicant must have the ability to clearly speak and read English, be 18+ years of age, female (due to nature of work), and pass a full state required background check. Position requires the ability to safely transfer 110 pounds with assistance. Approximately 10-12 hours per week depending on activities and availability. Employer would like a one-year commitment. Contact Molly Homemaker at 555-5555 for interview.

# WHERE TO ADVERTISE

Once you have identified the basic requirements that you need in an employee and have created a Help Wanted ad, you are ready to advertise.

The majority of high schools, applied technology schools, colleges and universities now utilize their own branches of Workforce Services. These localized branches are able to target a specific population and can help you in generating the most interest in your area. You, the employer, may choose the areas where you would like your ad to be available. Every county within the state of Utah has at least one Workforce Services office to help you.

You may contact a Workforce Services employee who can assist you posting your job listing on their site. You may be asked to provide your employer ID number that you have been given by your fiscal agent. Inform the Workforce Services employee that you are a small in-home state funded employer.

## Contacting Workforce Services

To find an employment center in your county, you may contact Workforce Services at:

**Utah Department of Workforce Services**
**P.O. Box 45249**
**Salt Lake City, UT 84145-0249**
**Phone: (801) 526-WORK (9675)**
**Fax: (801) 526-9211**

**Or, you may locate an office on-line at** www.jobs.utah.gov

Other excellent resources are your local newspapers. Be sure their circulation covers the area in which you live. Many grocers and local department stores are no longer allowing posting of job listings.

Sunday newspaper listings are generally the best. Costs will vary by paper, size of ad and date of listing. Consult your local newspaper for more information.

# SCREENING PROSPECTIVE EMPLOYEES BY PHONE

Once you have identified your needs, created an ad and posted it, you will need to begin screening potential job applicants. Most employment experts recommend an initial screening done over the phone. This will save time by eliminating applicants who do not meet your needs and requirements. DO NOT SET AN INTERVIEW TIME WITH SOMEONE WHO YOU DO NOT FEEL COMFORTABLE WITH ON THE PHONE! Thank them for their time and end the conversation.

Remember, applicants are asking you for a job and you get to make the hiring decision.

## The Phone Interview

When interviewing a possible applicant by phone begin by reviewing the basic requirements of the job. Review the following (add any questions you feel are pertinent to your situation and needs):

- Briefly cover requirements of the position, tasks involved, hours needed, etc.
- Ask about previous experience. Other jobs, volunteering, etc.
- Are they willing to be trained if needed?
- Availability- is the applicant able to work when you need them?
- Do they have reliable transportation?
- Are they flexible?
- Are they willing to commit to certain amount of time with you?
- Do they have other commitments?

## Pay Attention to:

- Is the applicant actively asking questions in return?
- Were you able to conduct a pleasant conversation?
- Does the applicant meet most of the required needs?
- Did you feel comfortable conversing with the applicant?

Be sure to take notes during your conversation. You may need to refer back to these during a face-to-face interview.

If, after your main conversation, you feel the questions have been answered to your satisfaction, and you are interested in the applicant, set an interview time to meet them at your convenience. (Optional) You may inform them that you will have them fill out an application at that time and would like them to bring a minimum of 2-3 references (no family references please) and a resume if they have one.

# HOW TO CONDUCT A JOB INTERVIEW

It is helpful for the person receiving services, if not conducting the actual interview, to be present during the interview process. Encourage them to have questions of their own for the applicant if possible. This will allow them to express their own preferences with the applicants and allow you, the employer, to observe interaction between the potential employee and the person they will support. Feel free to continue with your daily routine, if necessary, while interviewing. This is an opportunity to observe the individual in the work environment.

A job application is optional, (see sample in employer forms) but if you are not familiar with the person you may want to begin by having the applicant fill out an application. Keep this document on file until your decision has been made. Shred applications of applicants not hired and keep the application of the person you hired for their record. Review the application with the applicant; answering any other questions before moving on to interview questions.

The following is a list of possible questions you may wish to ask during an interview. It is recommended that you take notes as you go. Feel free to add questions that apply to your unique situation. These are to get you started.

## Possible Questions

- How would you describe yourself?
- How well do you work with people? Do you prefer to work alone or in teams?
- What experience have you had working with children/adults with disabilities?
- What is your favorite aspect of dealing with children/adults with disabilities?

- Have you had any classes or training in school that would help you with this job and how would this help?
- Do you feel qualified/capable to fulfill the requirements of the job and why?
- Availability and reliability are essential for this job. Tell me how you will meet the availability requirements for this position.
- Discuss flexibility and time commitment. Include weekends, holidays and evenings.
- What would you do if you were sick when you are scheduled to work?
- Identify a possible behavior problem common to your situation. Ask the applicant how they would deal with it.
- How would you evaluate your ability to deal with conflict?
- How long do you believe you will be available for this position?
- How well do you adapt to new situations?
- Why do you want to work for me?
- Discuss some of the more difficult aspects of the position. Ask if these are of concern to them and why.
- Discuss the positive aspects of the job.
- Ask, "Do you have any questions you would like to ask me?"
- Do you have any questions for the individual receiving services?
- Allow the person receiving services to ask questions.
- At the close of the interview be sure to tell the applicant you will be contacting them by phone with your decision. Give them a date (generally a few days after the interview) and stick with it. This will give you time to interview others, check references and think about your decision.

## Questions to Avoid

It is illegal and inappropriate, when hiring employees, to ask questions pertaining to the following identified protected areas included in the anti-discrimination laws:

- Race
- Color
- Age
- Religion
- Gender
- National Affiliation
- Disability
- Questions not related to the job
- Questions about employment history more that 5 years old

## Check References

Once the interview is over, think about how it went. Review your impressions with the person receiving services, family members, Support Coordinator and any others who may be able to help you with your decision. Was the applicant prompt? Well groomed? Did they answer questions to everyone's satisfaction? Any concerns brought to light during the interview that needs to be reviewed? If the applicant's face-to-face interview was successful, it is time to check references.

Unless this is the applicant's first job, you should do a reference check with at least one recent former employer. References from previous employers may be helpful in finding out about the applicant's work habits and personal characteristics. Check this reference first. Be aware many

employers may be hesitant to share too much information about former employees. Many employers will only verify previous employment. If this is the case, be sure to inquire if the former employee is eligible for rehire!

## The Following is a List of Possible Questions you May Choose to Ask When Conducting a Reference Check:

- How long have you known the candidate? In what relationship/capacity?
- What was the candidate's position?
- What were the candidate's responsibilities?
- How did the candidate get along with superiors, peers and subordinates?
- What were some of the candidate's outstanding accomplishments?
- Describe the candidate's leadership ability and responsibility level?
- What were the candidate's strengths? Weaknesses?
- Was the candidate on time?
- Why did the candidate leave?
- Do you feel the candidate can work effectively as a (title of job)?

# HIRING AND FIRING DECISIONS

## Hiring an Employee

Once you have obtained all the information you can on the applicant, review the information. Be sure to consider the wishes of the person receiving services when making the final choice. This is an important decision for you and your family. **Do not commit to hire an employee if you have ANY reservations.** After careful thought, make your decision. Be sure to notify all individuals awaiting a decision and be prompt with your notifications.

## Firing an Employee

Unfortunately, there are times when an employee does not perform their job duties appropriately. Dishonesty is immediate grounds for dismissal as is fraud, stealing and taking advantage of you, the individual receiving services, or the job in ANY way. Do not hesitate to immediately terminate an employee under these circumstances.

You may find an employee does not follow instructions, is consistently late or absent, does not make proper use of their time at work, does not complete assigned tasks, or has similar problems that affect their performance on the job. Realize YOU are the employer and not only do you need them to perform the job they agreed to do, you need to be happy with how that job is being performed.

If you are uncomfortable with your employee's job performance, explain your concerns and expectations. See if they can improve their performance within a mutually agreed upon time frame. It is a good idea to document this conversation and any agreements you arrive at. If, after the time period has passed, the employee has still not improved their performance and you remain unhappy with their work, you need to tell them you must terminate their employment.

Once you have reached this decision be sure to tell your employee how much longer, if at all, you will want them to work and under what circumstances. Be prepared for a possible "No-Show" by your employee, even if you have agreed to keep them on for a period of time.
Keep in mind the statement included in the Employment Agreement:

**"The Employee shall be employed At-Will by the employer. Employment At-Will means that employee may quit at any time for any or no reason, just as employer may discharge employee at any time for any or no reason. At-Will status may not be altered on behalf of the employer by any oral or written statement or promise by anyone".**

## One Last Detail

Whenever an employee is terminated, contact your Support Coordinator and Fiscal Agent and submit the employee termination form and the last timesheet to make sure that your employee is paid by the next pay period for work already provided.

# EMPLOYER INFORMATION for TRAINING and ORIENTATION of EMPLOYEES

Congratulations! You have found your employees and are ready to train them.

Training content is found in the Employee Training and Orientation Section 4, the Daily File you prepare and the Fiscal Agent Packet. **Have each of these items ready as you sit down to train your employee.** Contact your Support Coordinator if you have questions or need help understanding training requirements.

The following provides you with information needed to properly train your employees and manage your services.

- Helpful Hints for Employer Success
- Key Information
- Document Checklist – Who Gets What?
- DSPD Requirements
- Fiscal Agent Packet
- Employer Training

# HELPFUL HINTS FOR EMPLOYER SUCCESS

- Ensure your employee is properly trained and oriented to the work environment. This will allow the employee to provide the services you need.
- Be familiar with your Support Book *before* sitting down with your new employee. If you have any questions, be sure to contact your Support Coordinator. Be an informed employer.
- Read all documents and forms *before* you conduct an orientation.
- Get your documentation system in place before your employee orientation.
- Notify your Support Coordinator when you hire a new employee.
- Give your employee a work schedule *ahead of time* and at a set time each month. This will allow the employee to schedule any outside activities they need to complete around the work schedule.
- Give your employee advance notice if you need additional work time or need to cancel a shift.
- Communicate regularly with your employee. Develop a good working relationship with your employee to ensure they understand their duties and responsibilities. Be sure they feel comfortable in approaching you with problems or complaints, if need be.
- Teach your employee about the specific service they are being hired to do and the steps outlined in the Support Strategy so they are confident in what they are expected to do.
- Prepare a Daily File where Support Strategies, Emergency Contact Information, Timecards, blank Incident Reports and KEY information will be kept for easy reference.

- Give raises for good work and longevity of employment. Stay within accepted payroll parameters.
- Be flexible and understanding, but always maintain the role of employer.
- Submit time cards and comments to fiscal agents as required. It is your job to ensure your employee gets paid on time!
- Be approachable. Try to work through any conflicts that may arise. Inform your Support Coordinator if you need assistance in resolving a conflict.
- Stay in touch with your Support Coordinator in order to evaluate if current services continue to meet your needs.
- Inform your Support Coordinator of new employees you hire or when an employee is terminated.

## Ways to Support your Employee:

- Be patient with them while they learn.
- Encourage questions; something clear to you may not be clear to your new employee.
- Show appreciation for what your employee does well. Praise their efforts.
- Be kind and respectful, but firm in letting them know that they are to assist with and not direct the life of the person they support.
- Provide supplies needed to support the person. (Refer to Grab-and-Go Bags following.)

## **Grab-and-Go Bags** (Optional but a good idea!)

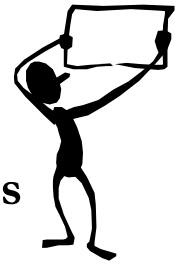
Depending on the services you use, you may want to consider putting together an individual Grab-and-Go Bag for use when leaving home or in case of an emergency evacuation. It is helpful to develop a list of items your family member would not want to be caught without while away from home. A backpack, diaper bag or small duffel bag can be used to carry items. These bags should be personalized for each person's needs and situation. The following is a suggested list of items:

- Emergency or routine medications (i.e.: rescue inhalers, seizure medication, etc.)
- Copy of emergency medical history (in sealed envelope)
- Copy of emergency contact numbers
- Extra medical supplies (tubing, dressings, moleskin, etc.)
- Basic first-aid kit
- Folding umbrella
- Flushable wipes in airtight container
- Personal hygiene supplies (incontinence pads, sanitary pads, diapers, etc.)
- Change of clothing (warm for winter and cool for summer)
- Jacket (and/or small blanket)
- Hat
- Sunscreen and bug spray
- Skin lotion

- Bottled water
- Approved snacks
- Formula or liquid meal supplements (Ensure, etc.)
- Gloves
- Hand-sanitizer
- Entertainment items (games, books, coloring supplies, CD player, radio with headset, items of personal preference, etc.)
- Personal medical equipment (walker, wrist/leg braces etc.)
- Two one-gallon zipper closure bags
- Toilet paper or facial tissues
- Small amount of extra cash
- Hex wrench set and adjustable crescent wrench (for wheelchairs or larger equipment)
- Flashlight
- Paper and pencil

# KEY INFORMATION

## For Training Employees and Managing Records



- Allow enough time to complete training prior to the first work session.

- Regularly check with your employees to see if contact information has changed, and update your records with the Fiscal Agent.

- Stay up to date! Read any DSPD updates as you receive them.

- Keep copies of ALL documentation for your records and to maintain the Employee File.

- Use the Employer Monitoring Tool to make sure your records are in order. (Employer Forms).

- Contact your Support Coordinator with any questions you may have or are unable to answer when training and orienting your new employee.

**The following pages outline DSPD, Fiscal Agent and Employer Requirements that all employers are responsible to complete with their employees when using Self-Administered Services.**

# DOCUMENT CHECKLIST

## Who Gets What?

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The table on the following page lists the required documentation to participate in Self-Administered Services and identifies who receives copies of each document.

**Note:** The State DSPD office in Salt Lake City receives the Background Screening Application, a copy of Utah driver's license or State picture ID, and fingerprint cards if employees have lived out of state more than 28 days in the past 5 years. Send to:

**Division of Services for People with Disabilities**
**Attention: (Background Screening)**
**120 N. 200 W. #411**
**Salt Lake City, Utah 84103**

# DOCUMENT CHECKLIST

| | Employer Record | Support Coordinator | Fiscal Agent | Employee | Employee File | DSPD |
|---|---|---|---|---|---|---|
| **Service Agreement Form 2-9SA** | X | X | | | | |
| **Incident Report Form** | X | X | | | | |
| **Employee Agreement Form 2-9EA** | | | X | X | X | |
| **Code of Conduct** | X | | | X | X Signature page | |
| **Copy of Driver's License** | | | X | | X | X With BSA |
| Background Screening Application (BSA) | | | | | | X |
| **Form I-9 Employee Verification** | | | X | | X | |
| **Time Sheet and Comments** | X | | X | | | |
| **Proof of Auto Insurance** | | | | | X | |
| **W-4 Form** | | | X | | X | |
| **Employee Certification Form 2-9C** | | X | | | X | |
| **Support Strategies** | X | X | | X Daily File | | |
| **Monthly Summaries** | | X | | | | |
| **Service Specific Training** | X | | | X | | |

# DSPD REQUIREMENTS

- *Employment Agreement - Form 2-9 EA
  Fill out all required sections, sign and date where indicated and most importantly, fill in the pay rate. Submit a copy to your Fiscal Agent and keep the original in the employee file.

- Department Code of Conduct - Policy 05-03
  Employee reads the Department Code of Conduct and signs the last sheet. The original signature sheet is kept in the employee file.

- *Employee Requirements for Certification - Form 2-9C or 2-9C(B)
  Complete all requirements noted on this form. Upon completion, submit to the Support Coordinator for their signature. The Support Coordinator will keep the original and make copies for the Fiscal Agent and you. Please DO NOT SEND to the Fiscal Agent.

- *Background Screening Application
  Fully complete the application including a copy of employees Utah driver's license or State picture ID and fingerprint cards of employees who have lived outside of the state for 6 consecutive weeks in the past 5 years. Send to:

**Division of Services for People with Disabilities**
**Attention: (Background Screening)**
**120 N. 200 W. #411**
**Salt Lake City, Utah 84103**

ALL employees, including family members, providing direct services to children or vulnerable adults receiving self-administered services MUST complete a Background Screening Application annually.

* Provided in the Fiscal Agent Packet.

## Key Information to Remember when Completing the Background Screening Application:

- READ the instructions.
- Be sure to enter the client ID# (this number is located in the Daily File, it begins with an 0).
- Complete all sections of the Background Screening Application (both sides).
- Enter complete full name. If there is no middle name enter N/A.
- Submit with a copy (legible and a clear picture) of State ID issued by the Division of Motor Vehicles or current Utah Driver's License or other.
- Submit fingerprint cards of employees that have lived out of state more than 6 consecutive weeks in the past 5 years if they are not the grandparent, aunt, uncle, sibling or child of your family member.
- Renewals will be sent to the employer's residence on an annual basis and need to be completed by your employees within 30 days.

**See Application and Instructions in Employer Forms section.**

**For questions contact the DSPD State Office at 538-4200 or the number on the Background Screening application form.**

# FISCAL AGENT PACKET

Request a current Fiscal Agent Packet before orienting a new employee. Complete all required forms found in the packet.

- Complete a W-4

- Employment Eligibility Verification - I-9
  Complete both sections for employer and employee.
  Include copies of two forms of ID. See reverse side of I-9 for the list of accepted documentation and further instructions.

- Train employees on how to complete timesheets and fill in comment area.

- Train employees on payroll schedule. When timesheets are due and when to expect paychecks, etc.

- Supply Employees with a copy of the Payroll Schedule (provided by the Fiscal Agent you may want to keep a copy in the Daily File)

**NOTE**: You and your Fiscal Agent are notified when an employee fails to pass the Background Screening. If this happens the Fiscal Agent will stop payments to the employee.

## Key Information when Paying Employees

- Keep a timesheet in the Daily File for your employees use each time they work. (Refer to the Daily File later in this section)

- Review the time in and out, accuracy of service provided, and comments made.

- Confirm that employees have entered the correct time worked and indicate a.m. or p.m. hours. (12:00 noon is p.m. and 12:00 midnight is a.m.)

- Make sure that time entered does not overlap with another service provided by the same employee.

- Sign the timesheet and fax or mail it to your Fiscal Agent by the deadline of the 1st and 16th of each month.

- Timesheets received on or before the 1st of the month will be paid on the 15th.

- Timesheets received on or before the 16th of the month will be paid on the 30th.

Variations in the payroll schedule may occur due to holiday and weekend dates. Refer to the Payroll Schedule in the Fiscal Agent Packet. You may want to add the current payroll schedule to your Daily File.

**Payroll may NOT be processed if it is received more than 30 days following the month services were provided.**

## Employee Rate Information Form

To establish or change your employee's rate of pay, turn in an Employee Rate Information Form. This form is included in the Fiscal Agents Packet. Refer to the Calculation Sheet to help you set a wage for your employees that is within your budget limit for each service.

## Employee Change/Termination Form

Complete the appropriate section of the Employee Change/Termination Form provided in your Fiscal Agent Packet if your employee's status changes and submit to your Fiscal Agent. This allows them to keep accurate records.

**Good Idea:** Keep contact information for your Fiscal Agent handy. If you have a problem, complaint, or suggestion, you can easily contact them. If you are asked to leave a message, leave details regarding your issue and give them a reasonable time to return your call.

You can find blank forms of your corresponding Fiscal Agent at one of the following websites:

Acumen: www.acumenfiscalagent.com
Morning Star: www.moriningstarfs.com
Leonard Consulting: www.leonardconsultingllc.com

Work with your Support Coordinator if you need to change from one Fiscal Agent to another.

## Contact Information and Notes:

_____

_____

_____

_____

# EMPLOYER TRAINING

Now that your have completed DSPD requirements and the Fiscal Agent Packet it is time to discuss specific employment issues for your family member receiving services.

Please train your employees to understand the following content. (Refer to the Employer Forms section for required and optional forms).

## Support Book

Your employees are required to complete the Employee Training and Orientation section of this Support Book. Use the Support Book as a reference and keep it in a public area, such as a living room bookcase or kitchen cabinet.

## Daily File:

Create a recording system for your employees to use each time they work referred to as a "Daily File". Information listed below that does not say "optional" is required to be in the Daily File.

- Incident Report Form
- Emergency Contact Information
- Current Support Strategies
- Timesheets and Comment Area
- Daily Notes (optional)
- Emergency Medical History (optional)
- Employee Instructions for Equipment (optional)
- Daily Medication Chart (optional)

**Good Ideas:** Post the Emergency Contact Information form near your home phone. Attach the sticky information card to the Daily File cover.

## Incident Reporting

Your **employees** are required to know what types of incidents need to be reported and reporting timelines.

**Employers** are responsible to train their employee as to what situations require an Incident Report form to be completed. Instructions are available in the Employee Training and Orientation Section 4 of this book. Incident Report forms are available in the "Employer Forms" section. Include a blank copy in the Daily File for your employees use.

**Employees** are responsible to complete an Incident Reporting form whenever an incident occurs **during their shift**.

It is required that you or your employee notify the Support Coordinator of any reportable incident that occurs *while the person is in the care of an employee*, within 24 hours of the occurrence. Initial notification may be in the form of phone, email or fax.

You or your employee must also complete an Incident Report Form and submit it to the Support Coordinator within five business days of the occurrence of the incident.

### The Following Situations are the Types of Incidents that Require the Filing of a Report:

- Actual and suspected incidents of abuse, neglect, exploitation, or maltreatment
- Drug or alcohol abuse

- Medication overdoses or errors requiring medical intervention
- Missing person
- Evidence of seizure in a person with no seizure diagnosis
- Property damage exceeding $500.00
- Physical injury requiring medical attention
- Law enforcement involvement
- Use of restraints or timeout rooms
- Any other instances that you, your family member or employee determine should be reported

After receiving an Incident Report, the Support Coordinator will review the report and determine if further action is necessary to ensure health and safety.

## Household Safety

As an employer it is your responsibility that your employees understand safety as it relates to your household. A completed outline is included in the Employee Training section. You may want to add additional content that is unique to your own home.

## House Rules

(Optional for employer use)

As an employer you may use the following outline to establish your household rules or include your own. You may choose to add this to the Employee Training section or the Daily File.

# House Rules

**Employees will:**

- Be on time when scheduled to work.
- Work the entire scheduled shift, unless released early by the employer.
- Follow DSPD guidelines as outlined by the Department of Human Services Code of Conduct and the Employee Agreement Contract at all times.
- The employee will adhere to the Support Strategy/Activity List etc. alterations to such routines must be made *only after consulting with the employer.*
- The employee is expected to be a positive role model for appropriate behavior, attire, and attitude while in direct contact with the person and family.
- It is appreciated if the employee will give as much notice as possible when requesting time off or vacation time.
- In the event of employee illness the employer must be notified ____ hours prior to the beginning of the shift.
- The employee will complete all shift related documentation BEFORE leaving at the end of the shift. Documentation may include: Timesheets, daily notes, medication charts, _____ etc.
- The employee will follow appropriate hand washing techniques *before and after* the following activities: Using the restroom, assisting the person in personal care activities (restroom included), food preparation, cleaning, etc.
- If you need to quit, please give as much notice as possible so that arrangements can be made for your replacement. Please understand that if you are unable to perform your work, are consistently late or absent, ignore instructions and rules, neglect your work or are dishonest, you will be terminated. If you are confused or have questions, please ASK!!

## Service Specific Training

You are required to provide your employees with information needed to support your family member and ensure their health and safety. Your employees will be more confident if information is given in writing for their reference, rather than hoping to remember what is said verbally. Keep the following trainings in either the Daily File or the Employee Training section of this book for employee reference.

- Transportation: A completed outline is included in the Employee Training section.

- Service Specific Training: As an employer you must provide your employees with specific written information to support your family member. A suggested format is provided in the "Employer Forms" and an example is shown on the following page. You may use this format or create your own

  Possible content areas for Service Specific Training:

  - Communication style
  - Medication taken
  - Physical needs
  - Dietary concerns or allergies
  - Important health needs
  - Special instructions for eating or swallowing
  - Age appropriate community activities and natural supports
  - Things the person likes, dislikes or fears
  - Physical limitation and concerns or equipment needs
  - How preferred recreational and leisure activities can be developed
  - Any other information specific to the disability

**NOTE:**

- If you request your employees to record medication taken by your family member during their shift, you may use the Daily Medication Chart provided in the Employer Forms. Notes on this form may include: medication taken or refused, time and employee signature.
- Include specific instructions necessary for your employee to understand if they are supporting your family member with medications.
- Employees should NEVER force medications.

Division of Services for People with Disabilities

# Service Specific Training
## (Direct Service Training)
## Self-Administered



**Date:** December 12, 2006
**For:** Joe Brown **Prepared by:** Joe & Mrs. Brown

Important information to know when providing services.

1. **Medication taken**

| Medication Name | Purpose | Possible Side Effects |
|---|---|---|
| Epi-pen / as needed | Allergic reaction | Rapid heart beat<br>Excessive sweating |
| Baclofin Pump | Muscle Tightness | Sleepiness<br>Nausea<br>Constipation<br>Complete muscle loss<br>Fever – confusion |
| Albuterol /Inhaler as needed | Respiratory Infection | Rapid heart rate<br>Flushing<br>Sweating |
| | | |

2. **Instructions for supporting medication:**
Assist Joe to grip inhaler and remind him to hold his breath when dispensing this medication.

3. **Physical needs** (list any illness, diagnosis, etc. the employee should be aware of when supporting the person)**:**
   Joe is diagnosed with Cerebral Palsy. He has recurrent urinary track infections and respiratory congestion.

4. **Dietary concerns or allergies** (note item and reaction)**:**
   Joe eats a regular diet, 3 meals a day, cut in small bite size pieces. Special formula drink given 2 hrs. after each meal.
   **Allergic to NUTS:** reaction starts with itchy mouth, cough, difficulty breathing. Epi-pen is in pocket behind wheelchair. Call 911 and guardian if problems persists after Epi-pen.

5. **Important health needs:**
   Joe needs to use different seating options, time out of his chair to minimize the problem with skin breakdown. Support Joe to drink, stay hydrated. He does not ask for drinks as he doesn't want to bother others. He uses a waterpack attached to his chair. Keep this clean and filled with fresh water.

6. **Special Instructions for eating or swallowing:**
   Cut food into bite size pieces. Joe uses a straw to drink.

7. **Note age appropriate activities or relationships important to the person:**
   (Age appropriate refers to activities that are similar to what peers at the same age may enjoy.)
   Joe likes swimming at the community pool. Talking on the phone with his friends in private. He attends a painting class with his uncle George on Thursday nights. Likes activities with peers and opportunities to meet girls.

8. **Things the person likes**:
   Swimming, going to the gym and working on upper body strength, having his privacy, riding the bus, being given time to express himself, talking with his doctors.

9. **Physical limitation and concerns or equipment needs:** (Refer to the How to Use Equipment form if needed.)
   Joe uses both a manual and power wheelchairs. He likes to use the manual for exercise-short walks etc. During outings he prefers his power chair for independence. Tool kit is kept in the backpack, check for positioning to support left leg. Assist with transfers, and provide respectful supervision.

10. **Discuss how the person's preferred recreational and leisure activities can be developed:** (This may be included on the Support Strategy.)
    Joe can be supported to make arrangements for activities with his friends. During outings introduce Joe to new bus routes and taking on greater independence on the bus and community by doing what he can for himself.

## Support Strategies

A support strategy is an **annual requirement** that identifies the steps to reach a goal that has been decided on by your family member receiving services and their team at the annual meeting. You may work with your Support Coordinator to develop your support strategies. Support Strategies are due to your Support Coordinator within 30 days of the annual meeting.

The Personal Goal: Reflects what is needed and important to the person.

The Vision/Purpose: States why the goal is selected and what is hoped to be gained.

Steps: Employees may see this as their "job description", what they are to do during their shift to address the goal. Be specific to the individual need.

**Good Idea:** You may want to keep a file for your Self-Administered Services on your computer. This may make it easier for you to annually update Support Strategies and Service Specific Training.

Following is an example of what a Support Strategy might look like. You will find a blank form in the Employer Form section.

# Support Strategies

**for**
**Self-Administered Services**
(Updated annually by Employer)


**For:** Joe Brown
**Annual Meeting Date**: December 3, 2007-December 31, 2007

**What is the Personal Goal?** (What is needed or important to the person.) "Joe wants to gain greater independence and physical strength"

**What is the Vision/Purpose of the Goal?** (What is hopped to be gained.) The Vision is that Joe will become stronger and able to manage more of his personal needs and have more independence.

**When will these steps be followed?** During all scheduled sessions with his staff

**Who will follow these steps?** Staff providing Personal Assistance

**Employees will support this goal by following these steps:**

- Employees will provide support in weight bearing activities that Joe enjoys such as, using the ball, stander/walker, and swimming.
- Employees will support Joe with range of motion and stretching taught by Mrs. Brown
- Employees will support Joe in life skill activities, such as dressing, bathing and eating.
- Employees will encourage Joe to participate as independently as possible
- Employees will report any physical or emotional needs or changes to the Browns.
- Staff will make a brief comment on the timesheet related to the goal, at the conclusion of the session provided to support Joe.

## Monthly Summary

A monthly summary is **required** and tells what has happened during the previous month to address the goal. Summaries should be shared in a way that works for you and your Support Coordinator. The summary is due to your Support Coordinator by the 15th of each month and can be done in a written note, an e-mail, a telephone conversation, or during a visit in your home. Whichever method you use, it is important that you provide the information listed on the format in the following page.

**A summary is required for each goal.**

**Good Idea**: You could give this information to your Support Coordinator at the same time that you submit your timesheets.

NOTE: Update your Support Coordinator of new employees, fired employees or needs with finding or keeping employees.

Following is an example of what a Monthly Summary might look like. You will find a blank form in the Employer Form section.

# Monthly Summary


for

**Self-Administered Services**

**For:** Joe Brown

**Month/Year:** November 2006

Please provide a summary of progress of each goal. (for each goal, describe the support given, how successful the support was and if this continues to meet the needs of the person receiving the service) Use back of form if necessary.

**Goal:** Joe will gain greater independence and physical strength

**Summary:**

During the month of November, Joe had regular support from his Personal Assistant Kim who helped him work on this goal. Joe is beginning to take the initiative in using his walker and has recently walked from one end of the living room to the other. We are seeing good progress. Kim and Joe have also found a community pool that Joe likes. He will have additional support there to get him in and out of the pool.

**Goal:** _____

**Summary:**

**Health Concern: Stable** ____ **Increased** ____ **Decreased** __**X**____

**Comments:** Joe is breathing better, probably because of the change in weather and increased movement. His recent Dr. appointment went well.

**Revisions of Service Needed:** Need additional service in February

**Changes with Employees:** Plan to add a new employee next week.

**Additional Comments:** I'd like to talk to you about Joe's upcoming IEP meeting at school on January 7. I hope you can come and give me some good ideas.

**Employer Signature:** Mrs. Brown **Date:** December 11, 2006

# HOME PROGRAM MANAGEMENT

You as an employer you may want to monitor your records and are required keep documentation in the following areas.

- Employer Monitoring Tool
- A Daily File (Short Term)
- A Filing Cabinet (Long-Term Maintenance)
- Employee File Information

# Employer Monitoring Tool

## for
## Self-Administered Services

As an employer you'll want to know that your program is first rate. You will have greater success if you keep your records organized and review them on a regular basis. The monitoring tool on the following page can be used at any time to check your records to meet requirements. Your Support Coordinator is able to supply you with any items you are missing and answer any questions you may have.

Following is an example of what a completed Employer Monitoring Tool might look like. You will find a blank form in the Employer Form section.

# Employer Monitoring Tool
## for
## Self-Administered Services


**Employer Records:**

__X__ Current Service Agreement Form 2-9SA dated Dec. 1, 2006

__X__ A Daily File contains: Emergency Contact Information, Support Strategies, Blank copies of Incident Reports and Timesheets.

__X__ Service Specific Training identifying relevant information about the family member.

__X__ Current Support Strategies dated _January 2007_____

__X__ Monthly Summaries are provided to my support coordinator using a:
Written format __X__ Phone contact _____ Home or office visit ___
E-mail _____

**Employee Records**:

__X__ Employees have been trained on all required content found in the Employee Training Section of the Support Book, Daily File, and Timesheets.

__X__ The Form 2-9C - Application for Certification has been completed by my employees and it is in their Employee File.

__X__ Employees providing transportation have a copy of their Utah Driver's License and proof of insurance in their Employee File and are 18 years of age or older.

__X__ Employees are trained on Time Card processes and bill for exact services provided.

_____ Employees understand how to complete comments on a Timesheet.

__X__ Annual Background Screening Applications (BSI) have been completed by all employees.
Date for each employee: _John T. November 2006_____

___X Employees are providing only services that are reflected on the budget and Action Plan.

Questions for my Support Coordinator. (use back)

How do I add comments on timesheets?

# DAILY FILE
(Short Term)

A Daily File is used to keep important information necessary for your employee to use each time they work. It will provide them with "KEY" information to do their job and support your family member.

**Good Idea:** Consider using a 4-6 section folder or a 3 ring binder to organize your Daily File and keep it in a place that both you and your employee can access on a regular basis.

## Maintain the following information in the Daily File.

**Required:**

- Emergency Contact Information
- Current Support Strategies
- Timesheet with comment area
- Incident Report form (blank copies)

**Optional:**

- Service Specific Training (for quick reference)
- Daily Notes
- Emergency Medical History
- Employee Instructions for Equipment
- Daily Medication Chart
- Employee Schedule/Calendar
- Payroll Schedule
- Monthly Summary (for your use)
- Fiscal Agent Information or communication
- DSPD communication (updates)

# FILING CABINET
## (Long-Term Maintenance)

The following documents **must** be maintained for five years and easily accessible. It is recommended that you obtain a file box or cabinet to store these documents.

1. Service Agreement – Form 2-9SA
2. Service Plans and Budgets
3. Support Strategies/Monthly Summaries.
4. Past Employee Information. (Destroy after 5 years)

**Good Idea:** Keep each year's information in it's own folder or packet for easy reference and identify with that year's date.

# EMPLOYEE FILE INFORMATION

Maintain the following documents in a confidential employee file.

**Required:**

- Copy of auto insurance policy (if transporting)
- Copy of employee's driver's license (if transporting)
- Copy of social security card
- Original W-4 form
- Original I-9
- Signature sheet of the Department Code of Conduct (Directive 1.20)
- Signed copy of Employment Agreement - Form 2-9EA or 2-9EA(B)
- Signed copy of Employee Certification – Form 2-9C or 2-9C(B)
- Background Screen verification

**Optional:**

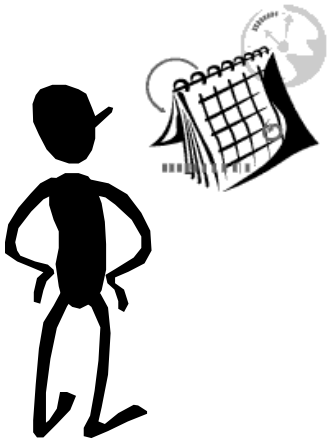
- Application for Employment
- Resume and references with employer notes
- Any supporting documentation (copies of professional licensure, etc.)

# EMPLOYER ANNUAL REQUIREMENTS

You and your Support Coordinator are responsible to update specific information at your family members annual meeting, and prior to the beginning of the fiscal year. The following pages provide you with information needed to meet these requirements. **Failure to complete these requirements may result in not being able to continue to use self-administered services.**

## <u>This Section Includes</u>:

- Fiscal Year Requirements
- Annual Meeting Requirements



# FISCAL YEAR REQUIREMENTS

The fiscal year is from July 1 through June 30. You will meet with your Support Coordinator to discuss your services and assess your current needs prior to July 1, each year.

## Support Coordinators Responsibilities:

- Reviews and signs the Service Agreement with you, the employer. Provides you with a copy for your records.
- Reassesses needs and services
- Reviews, signs and obtains copies of your budget
- Provides you with a copy of the budget and any service changes or addendums to Individual Service Plan (ISP) indicating any new services selected

## Employer Responsibilities:

- Shares information regarding the use or need of services
- Reviews, signs and receives a copy of the budget
- If new services are selected, makes necessary updates to Support Strategies and trains employees to meet them

# ANNUAL MEETING REQUIREMENTS

Your Support Coordinator will lead this meeting with you and your family member to review service needs and select new goals. You and others who are helpful in sharing information important to and for your family member are able to make this annual meeting meaningful. Once the meeting is over, the Support Coordinator completes an Individual Service Plan (ISP) as part of the person-centered planning process.

## Support Coordinator Responsibilities:

- Reviews, updates, and gathers assessment information.
- Reviews the selected goals with your family member and the team at the meeting.
- Prepares an Individual Service Plan (ISP) identifying Medicaid services being purchased, an Action Plan with selected goals, and reviews and/or updates the budget.
- Assists, and follows-up if needed, with you to ensure that Support Strategies are completed for your employees to follow within 30 days of the meeting.
- Provides technical assistance to manage Self-Administered Services.
- Monitors your records.

## Employer Responsibilities:

- Reviews records prior to the annual meeting using the Employer Monitoring Tool (optional but helpful).

- Updates Support Strategies developed from the goals identified on the Action Plan at the annual meeting.

- Updates Service Agreement (agreement between DSPD and you) provided by your Support Coordinator annually.

- Updates Service Specific Training for employees.

- Confirms that the Background Screening Application (BSA) has been completed **annually** for each employee.

# EMPLOYER FORMS

This section provides you with blank original forms that you may copy as needed to Self-Administer your services and keep for your own records.

Contact your Support Coordinator for additional forms or assistance.

## This Section Includes:

- Blank Forms for Your Records
- Blank Forms for Your Employees
- Blank Forms for the Daily File

**Good Idea**: Find Self-Administered Services forms by accessing www.hsdspd.state.ut.us Programs and Services, Self Administered Services, Related Links (on right side of your screen), Self Administered Services Forms. Or by accessing your Fiscal Agent website.

# BLANK FORMS FOR YOUR RECORDS

- Self-Administered Services Agreement (Form 2-9SA)
- Incident Report Form
- Employer Monitoring Tool
- Support Strategies Form
- Monthly Summary Form
- Authorization to Give Consent
- Service Specific Training Form

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

**SELF-ADMINISTERED SERVICES AGREEMENT**
**Employer Agreement**

**PARTIES:** This Self-administered Services Agreement (referred to hereafter as "Agreement") is between the Utah Department of Human Services ("DHS"), Division of Services for People with Disabilities ("DIVISION"),

**AND**

Name of Person receiving services (PERSON)/Person's Representative: _____

Address (Circle: **Person/Person's Representative**): _____

_____

**Representative(s):** On _____,200_ I was informed of my responsibilities in participating in this program and hereby authorize the individual named below to assist me in administering this Self-administered Services Agreement (Signature of Person/Person's Representative)_____

Name of Administrator (If different than the Person's Representative) _____

Address: _____

(The Person, Representative, and Administrator are referred to in this Agreement as the "PERSON/PERSON'S REPRESENTATIVE." Oftentimes the Representative and Administrator will be the same individual.).

**PURPOSE:** To define responsibilities and allocate funds to the PERSON/PERSON'S REPRESENTATIVE to buy specific services identified in this Agreement for _____ _____ *(insert individual's name and USSDS #)* (referred to in this Agreement as the PERSON). The PERSON is eligible, and has been authorized by the DIVISION, to receive the specific services identified in this Agreement as listed in his or her Action Plan, dated _____.

SELF-ADMINISTERED SERVICES AMOUNT: the DIVISION approves the following amount, $_____(*insert amount in General Funds),* as an authorized spending limit for the purchase of Self-administered Services that may be matched with Federal Funds for a budget of $_____(*insert amount of total allocation for this program),* to be used toward the purchase of the specific services authorized by the DIVISION and identified below for the PERSON. (*Check all services that apply*).

| | | |
|---|---|---|
| Chore Services (CH1) | Hourly _____ | |
| Companion Services (CO1) | Hourly _____ | |
| Companion Services (CO1) | | Daily _____ |
| Family Training and Preparation Services (TF1) | Hourly _____ | |
| Homemaker Services (HS1) | Hourly _____ | |
| Personal Assistance (PA1) | Hourly _____ | Daily _____ |
| Respite care (RP1) | Hourly _____ | Daily _____ |
| Respite Care with Room and Board (RP6) | | Daily _____ |
| Respite-Group (RP7) | Hourly _____ | Daily _____ |
| Respite-Group with Room and Board (RP8) | Hourly _____ | Daily _____ |
| Supported Living (SL1) | Hourly _____ | |
| Transportation (DTP) | Per Mile _____ | |

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

**SELF-ADMINISTERED SERVICES AGREEMENT**
**Employer Agreement**

In addition, the following services are available to all persons determined to have a need and are enrolled in the Division's Medicaid MR.RC waiver. These additional services may be provided using a combination of Agency-based Provider Services, and Self-administered Services:

- Behavioral Consultation Services (**BC1, BC2, BC3**),
- Day Supports-Individual Services (**DSI**),
- Day Supports-Group Services (**DSG**),
- Environmental Adaptations (**EA1, EA2),**
- Financial Management Services **(FMS),**
- Living Startup Costs (**STC**),
- Massage Therapy (**SSM**),
- Personal Emergency Response Services (**PEI, PEM, PEP, PER**),
- Professional Medication Monitoring Services (**PM1, PM2),**
- Residential Habilitation Services (**RHI, RHS, PPS, HHS**)
- Respite-Session (**RPS)**
- Supported Employment Services (**SEC, SED, SEE, SEI**)
- Specialized Medical Equipment (**SM1, SM2, SME**).

**SPECIAL CONDITIONS:**. The DIVISION may change the Self-administered Services amount covered by this Agreement at any time in order to reflect changes to the PERSON's Action Plan or changes in the PERSON's assessed needs with 30 days written notice.

**AGREEMENT PERIOD:** This Agreement is effective on _____ *(insert date)* and terminates at the end of the fiscal year, June 30, 200__ *(insert date)* unless terminated sooner under the terms and conditions of this Agreement.

**DISBURSEMENT OF FUNDS:** The funds identified in this Agreement will only be used to pay for actual services rendered. All payments will be made through a Fiscal Agent under contract with the DIVISION. The Fiscal Agent selected by the PERSON/PERSON'S REPRESENTATIVE is _____. Payments will only be issued and mailed directly to the actual employee hired by the PERSON/PERSON'S REPRESENTATIVE. Supporting documentation, as required by Administrative Rule R539-5 must accompany all requests for payment. The DIVISION will not pay for services that exceed the Self-administered Services amount. Nor will the DIVISION pay for services not identified and approved in this Agreement. The DIVISION has authority over any SELF-ADMINISTERED SERVICE AMOUNT that remains unspent at the end of this agreement. Neither the PERSON/PERSON'S REPRESENTATIVE nor the PERSON has any right to, or claim upon, the unused balance.

**PERSON/PERSON'S REPRESENTATIVE RESPONSIBILITIES:** In addition to the requirements otherwise set forth in this Agreement, the PERSON/PERSON'S REPRESENTATIVE shall be responsible for the following:

1. Comply with the Department Code of Conduct (Policy 05-2) and applicable DIVISION Administrative Rules.
2. Supply all required information to the Support Coordinator and Fiscal Agent as outlined in Administrative Rule R539-5.

3. Hire, fire, direct, and train Employees to support the PERSON as outlined in the Individual Support Plan, Action Plan, Behavior Support Plan, Support Strategies, and applicable DIVISION Administrative Rule. Ensure that each employee is qualified to provide the services for which he/she is employed and that all billed services are actually provided. The PERSON/PERSON'S REPRESENTATIVE shall also assure that each Employee complies with all DIVISION Directives, Administrative Rule R539-5, Training Requirements, the DHS Code of Conduct, and is a certified Medicaid Provider.

4. When appropriate ensure specialized training needs, such as behavioral or other person-specific (i.e…medical) training, are provided to employees prior to the provision of such services.

5. Verify that all Employees hired are sixteen (16) years of age or older <u>for all services with the exception of transportation services and all overnight services where the employee must be eighteen (18) years of age or older.</u> Employee's Employment Agreement for individuals under eighteen (18) must be co-signed by their parent or guardian.) Parents, Guardians, and stepparents shall not be paid to provide support to their child, nor shall an individual be paid to provide support to his or her spouse

6. Ensure that all Employees understand the approved and prohibited Behavior Supports as identified in Administrative Rule R539-3, the Support Book, and any other best practice sources recommended by the DIVISION

7. Participate in the Person Centered Planning process and in the development of Support Strategies. The PERSON/PERSON'S REPRESENTATIVE must complete support strategies within 30 days after the completion of the Action Plan. The PERSON/PERSON'S REPRESENTATIVE shall also communicate with the DIVISION Support Coordinator on the effectiveness of the plan, identified strategies, and desired outcomes through Monthly Summaries submitted to the Support Coordinator by mail, fax, or email;

8. Immediately notify the DIVISION Support Coordinator of any changes or emergencies, which may require a change in the type or amount of services in the Person's Action Plan;

9. Incident Reports
    a. The PERSON/PERSON'S REPRESENTATIVE shall notify the Support Coordinator by phone, email, or fax of any incident that occurs **while the PERSON is in the care of an Employee**, within 24 hours of the occurrence.

    b. <u>Within five business days</u> of the occurrence of an incident, PERSON/PERSON'S REPRESENTATIVE shall complete a Form 1-8 Incident Report and file it with the Support Coordinator.

    c. The following situations are incidents that require the filing of a report:
        1) Actual and suspected incidents of abuse, neglect, exploitation, or maltreatment.

2) Drug or alcohol abuse or medication overdoses or errors reasonably requiring medical intervention;
3) Missing PERSON;
4) Evidence of seizure in a PERSON with no seizure diagnosis;
5) Significant property destruction (Damage totaling $500.00 or more is considered significant.);
6) Physical injury reasonably requiring a medical intervention;
7) Law enforcement involvement;
8) Use of mechanical restraints, time-out rooms, or highly noxious stimuli that are not outlined in the Behavior Support Plan, as defined in R539-4; or
9) Any other instances the PERSON/PERSON'S REPRESENTATIVE determines should be reported.

10. Comply with any requests for home visits to inspect program quality and conduct Agreement compliance reviews, and with the DIVISION requests to administer customer satisfaction surveys.

11. Comply with all requirements of the Fiscal Agent to ensure accurate records and prompt payroll, including: reviewing and signing employee time cards; verifying the accuracy of hours worked; ensuring the appropriate expenditure of funds; and completing, maintaining and filing all necessary tax information required by the Internal Revenue Service.

**REVIEW OF PERSON/PERSON'S REPRESENTATIVE'S BILLINGS:** The DIVISION as well as the State Medicaid Agency (SMA) may review all billings submitted by the PERSON/PERSON'S REPRESENTATIVE to the Fiscal Agent for payment and may deny payment if any charge is not properly supported. The Person/Person's representative is still responsible to pay their employee(s) for any services actually provided.

**PROVIDER AGENCY OPTION**: Person/Person's representative may use some or all of their allotted budget, based on assessed need, to obtain services through Provider Agencies if their so choose.

**RECORD KEEPING RESPONSIBILITIES:** The PERSON/PERSON'S REPRESENTATIVE shall maintain copies of all required records for a minimum of six (6) years pursuant to §63-2-201, UCA.

**USE OF PUBLIC FUNDS:** The funds covered by this Agreement are public funds and as such they are subject to all applicable federal, state, and local laws and regulations pertaining to the use of public funds.

**MISUSE OF FUNDS:** The misuse of any of the funds provided under this Agreement, that is using funds for purposes other than authorized, is illegal and may lead to criminal prosecution, administrative sanctions, and liability for repayment of the misused funds.

**PERSON/PERSON'S REPRESENTATIVE LIABILITY**: The PERSON/PERSON'S REPRESENTATIVE has sole responsibility for hiring Employees to provide services for or on behalf of the PERSON.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

**SELF-ADMINISTERED SERVICES AGREEMENT**
**Employer Agreement**

In accordance with 62A-5-103.5, the DIVISION requires PERSON/PERSON'S REPRESENTATIVES to obtain a criminal and abuse registry screening on all employees (except immediate family) who provide direct service care. Immediate family (grandparents, aunts, uncles, brothers or sisters) require only an abuse registry screening, the criminal background check is not required for immediate family. As a condition of the Employment Agreement, the Employee will fully disclose any convictions from a criminal offense other than a traffic violation and will promptly submit to a background criminal investigation.

In addition, the DIVISION recommends that the PERSON/PERSON'S REPRESENTATIVE obtain a TB test within one year prior to employment and no later than two weeks after employment, through their local Public Safety and Health agency and to provide Employees with extensive training on health and safety issues.

It is the PERSON/PERSON'S REPRESENTATIVE'S full responsibility to select, screen, and train employees to protect the health and safety of the PERSON. By choosing to participate in the Self-administered Services program, the PERSON/PERSON'S REPRESENTATIVE accepts all liability for any harm to the PERSON, or others, resulting from any action or inaction of the PERSON/PERSON'S REPRESENTATIVE in conducting screenings or tests on any Employee, or in providing or not providing training in any specific area.

The PERSON/PERSON'S REPRESENTATIVE further agrees to indemnify (hold harmless) the DIVISION, DHS, and the State of Utah for the full amount of any judgment rendered against any one or more of them as a result of any action or inaction of any Employee hired by PERSON/PERSON'S REPRESENTATIVE.

**TERMINATION OF THIS AGREEMENT:** This Agreement may be terminated by the PERSON/PERSON'S REPRESENTATIVE at any time, or by the DIVISION with 30 days written notice. In addition, the DIVISION may immediately terminate this Agreement at any time upon discovery of misuse of Self-administered Services funds or any other action taken by the PERSON/PERSON'S REPRESENTATIVE pursuant to this Agreement that endangers the life or safety of the PERSON.

**JURISDICTION:** The provisions of this Agreement are to be governed by and interpreted according to the laws of the State of Utah. The parties shall submit to the jurisdiction of the courts of the State of Utah for any dispute arising under this Agreement or relating to its breach.

**SEPARABILITY CLAUSE:** A finding by any court or other binding legal body that any part of this Agreement is illegal or void shall not affect the legality or enforceability of any other independent part of this Agreement.

**QUESTIONS ABOUT THIS AGREEMENT** should be directed to the support coordinator.

**As PERSON/PERSON'S REPRESENTATIVE, my signature acknowledges that I have read, understand, and agree to all the terms of this Agreement. In addition, I have received a copy of, read, understand, and agree to abide by the DIVISION'S Administrative Rule pertaining to this Self-administered Services Agreement and use of a Fiscal Agent. I understand that the failure to comply with any of the terms of this Agreement may result in my loss of the privilege to receive Self-administered Services now and in the future.**

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

**SELF-ADMINISTERED SERVICES AGREEMENT**
**Employer Agreement**

**As PERSON/PERSON'S REPRESENTATIVE, my signature also acknowledges that the DIVISION does not endorse or recommend any Employee to be hired or to provide services under this Agreement. In consideration of these promises and representations, and IN WITNESS WHEREEOF, the parties have executed this Agreement as of the effective date indicated.**

**PERSON/PERSON'S REPRESENTATIVE(S)** (Person/Person's Representative)

_____
***Type or print name***

_____
Signature

**Date:** _____

***(if designated)***
AUTHORIZED ADMINISTRATOR

_____
***Type or print name***

_____
Signature

**Date:** _____

**DIVISION REPRESENTATIVE**

_____
***Type or print name***

_____
***Signature***

**Date:** _____

Utah DHS-DSPD
5/03

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES



**FORM 1-8**

# INCIDENT REPORT FORM

| | | |
|---|---|---|
| PERSON'S ID: 0___ ___ ___ ___ ___ ___ ___ ___ | PERSON'S NAME: | |
| TODAY'S DATE: ____/____/____ MM DD YY | DATE INCIDENT STARTED: ____/____/____ MM DD YY | TIME INCIDENT STARTED: _____ AM/PM |
| YOUR NAME: | DATE INCIDENT ENDED: ____/____/____ MM DD YY | TIME INCIDENT ENDED: _____ AM/PM |
| YOUR TITLE: | YOUR PHONE NUMBER: ( ) | |
| PROVIDER NAME: | PROVIDER SITE ADDRESS: | City: |
| NUMBER OF PEOPLE INVOLVED (INCLUDING PERSON IN SERVICES LISTED ABOVE): | | |

**NAMES and ROLES OF OTHERS INVOLVED or WITH PERTINENT INFORMATION, INCLUDING HEALTH CARE PROVIDERS, IF ANY:**
***(DO NOT INCLUDE PERSON IN SERVICES LISTED ABOVE):***

| | |
|---|---|
| NAME: | ROLE: |
| NAME: | ROLE: |
| NAME: | ROLE: |
| WHERE DID INCIDENT TAKE PLACE? | ☐ Provider Site Listed Above ☐ Day Program ☐ School ☐ Friend's Home ☐ Relative's Home ☐ Other Location (Describe Briefly): |

**ACTION TAKEN?**

| | | |
|---|---|---|
| MEDICAL PROFESSIONAL NOTIFIED? | ☐ Yes ☐ No | Name: Title: Phone: |
| PERSON HOSPITALIZED? | ☐ Yes ☐ No | Hospital's Name: Phone: |
| POLICE NOTIFIED? | ☐ Yes ☐ No | Date: ____/____/____ Time:_____ AM / PM |
| APS or CPS NOTIFIED? | ☐ Yes ☐ No | Date: ____/____/____ Time:_____ AM / PM |

**TYPE OF INCIDENT?**

| | |
|---|---|
| ☐ **INJURY** | Who Was Injured? ☐ Person in Services ☐ Another/Other Person(s) in Services ☐ Staff ☐ Other:<br>Who caused the injury? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other:<br>Body part(s) injured:<br>Severity/Treatment: |
| ☐ **ABUSE** | Who was abused? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other:<br>Who caused the abuse? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other:<br>Type of Abuse/Exploitation: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Financial<br>Abuse was: ☐ Observed ☐ Suspected<br>Severity/Treatment: |
| ☐ **CRIMINAL ACT** | Type of Act: |
| ☐ **DRUG/ALCOHOL** | ☐ Incident ☐ Overdose<br>Drug/Alcohol involved:<br>Severity/Treatment: |
| ☐ **Med Error** *(Resulting in Medical Procedure)* | Medication(s) involved:<br>Severity/Treatment: |
| ☐ **Missing Person** | Date Last Seen: ____/____/____ Time Last Seen:_____ AM / PM<br>Where last seen?<br>Date Found/Returned: ____/____/____ Time Found/Returned:_____ AM / PM |
| ☐ **SEIZURE**[1] | Duration:<br>Brief Description of Event: |
| ☐ **RESTRAINT**[2] Authorized by:<br>Name:_____<br>Title:_____ | Cause: ☐ Aggression ☐ Self-Injurious Behavior (SIB) ☐ Other:<br>Number of Minutes Person was Restrained: |
| ☐ **Property Destruction**[2] | Item(s) Destroyed: Cost to repair/replace? $_____.____<br>Owner(s) of Item(s) destroyed: |
| ☐ **OTHER INCIDENT** | Please provide brief description: |

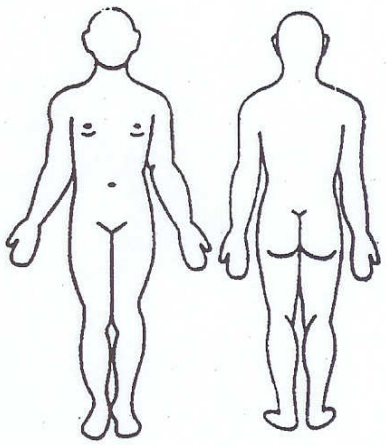
[1]If person has a diagnosis of Seizure Disorder, a monthly summary of seizures may be used instead of this form.
[2]If person destroys property or is restrained more than once a month, a monthly summary of incidents may be used instead of this form.

**FORM 1-8**

# INCIDENT REPORT FORM

**Describe Incident in Detail;**
**Include How Each Person Was Involved:**

**Please mark the body parts injured**



| **Provider Signature:** | **Title:** |
|---|---|

**Support Coordinator Recommendation / Follow-Up:**
*(Attach APS or CPS Referral Sheet and Final Outcome of Investigation)*

| **Support Coordinator Signature:** | **Date Notified:** | **Today's Date:** |
|---|---|---|

# Employer Monitoring Tool

## for
## Self-Administered Services

**Employer Records:**

_____Current Service Agreement Form 2-9SA dated _____

_____ A Daily File contains: Emergency Contact Information, Support Strategies, Blank copies of Incident Reports and Timesheets.

_____Service Specific Training identifying relevant information about the family member.

_____Current Support Strategies dated _____

_____Monthly Summaries are provided to my support coordinator using a:
Written format _____ Phone contact _____ Home or office visit _____
E-mail _____

**Employee Records**:

_____Employees have been trained on all required content found in the Employee Training Section of the Support Book, Daily File, and Timesheets.

_____The Form 2-9C - Application for Certification has been completed by my employees and it is in their Employee File.

_____Employees providing transportation have a copy of their Utah Drivers License and proof of insurance in their Employee File and are 18 years of age or older.

_____Employees are trained on Time Card processes and bill for exact services provided.

_____ Employees understand how to complete comments on a Timesheet.

_____Annual Background Screening Applications (BSI) have been completed by all employees.
Date for each employee: _____

_____Employees are providing only services that are reflected on the budget and Action Plan.

Questions for my Support Coordinator. (use back)

# Support Strategies



## for
## Self-Administered Services

(Updated annually by Employer)

**For:** _____
**Annual Meeting Date:** _____

**What is the Personal Goal?** (What is needed or important to the person.) _____
_____

**What is the Vision or Purpose of the Goal?** (What is hoped to be gained.) _____
_____
_____

**When will these steps be followed?** _____

**Who will follow these steps?** _____

**Employees will support this goal by following these steps:** (list)
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

# Monthly Summary



## for
## Self-Administered Services

(Information due to the Support Coordinator by the 15th of the month following services)

**For:** _____
**Month/yr**: _____

Please provide a summary of progress of each goal. (For each goal, describe the support given, how successful the support was and if this continues to meet the needs of the person receiving the service) Use back if necessary.

**Goal**: _____

**Summary**:
_____
_____
_____
_____

**Goal**: _____

**Summary**:
_____
_____
_____

**Health Concerns**: **Stable** _____ **Increased**_____ **Decreased**_____

**Comments:** _____
_____

**Revisions of Service Needed**: Yes / No_____
**Employee Changes**: _____
**Additional Comments**: _____
_____

Employer Signature_____ Date: _____

# Authorization to Give Consent



I, the parent/guardian or representative of _____

Authorize: _____

As my/our employee to consent to any emergency medical, dental or surgical treatment and hospital care which is deemed advisable and is to be performed by or under the supervision of any licensed physician, surgeon, or dentist. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required. It is further understood that the person(s) authorized will make every effort to contact the parent/guardian or representative in the event of this emergency.

_____ _____

Parent/Guardian, Representative Date

# Service Specific Training



## for
## Self-Administered Service Employees

**Date:** _____
**For:** _____ **Prepared by:** _____

Important information to know when providing services.

1. **Medication Taken**

| Medication Name | Purpose | Possible Side Effects |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

2. **Instructions for supporting medication:**

_____
_____
_____

3. **Physical Needs** (list any illness, diagnosis, etc. the employee should be aware of when supporting the person.

_____
_____
_____

4. **Dietary concerns or allergies** (Note item and reaction):

_____
_____
_____
_____

5. **Important Health Needs:**

_____
_____
_____
_____

6. **Special instructions for eating or swallowing:**

_____
_____
_____

7. **Note age appropriate activities and or relationships important to the person.** (Age appropriate refers to activities that are similar to what peers at the same age may enjoy)

_____
_____
_____

8. **Things the person likes:**

_____
_____
_____

9. **Physical limitations and concerns or equipment needs:** (refer to the How to Use Equipment form if needed)

_____
_____
_____

10. **Discuss how the person's preferred recreational and leisure activities can be developed?** (This may be included on the Support Strategy)

_____
_____
_____

# BLANK FORMS FOR YOUR EMPLOYEES

- Application for Employment (optional)
- Department Code of Conduct – (Policy 05-03) and Signature Sheet (Each employee must sign the last sheet and maintain in employee file.)
- *W-4 - Form
- *I-9 - Form
- *Background Screening Application (complete annually)

## Specific to Community Support Waiver (CSW)

- *Employment Agreement - Form 2-9EA
- *Application for Certification - Form 2-9C

## Specific to Acquired Brain Injury Waiver (ABIW)

- *Employment Agreement - Form 2-9EA (B)
- *Application for Certification - Form 2-9C (B)

Keep these forms in the Employee File. * Provided in Fiscal Agent Packet

# Application for Employment

(Optional for employers use)

NAME: _____

ADDRESS: _____

US Citizen or Legal work status: Yes only _____

Phone Numbers: Home _____ Work _____ Other: _____

References: (List at least 2)

1. Name: _____ How do they know you? _____
   How long have they known you? _____
   Address: _____ Phone: _____

2. Name: _____ How do they know you? _____
   How long have they known you? _____
   Address: _____ Phone: _____

3. Name: _____ How do they know you? _____
   How long have they known you? _____
   Address: _____ Phone: _____

(Use the back if needed)

List past employment and responsibilities:

Why are you interested in this position?

What might be some of your interests that will help you in this position?

| DEPARTMENT OF HUMAN SERVICES<br>POLICY AND PROCEDURES | | |
|---|---|---|
| **Reference: 05-03** | **Effective Date: May 23, 1989**<br>**Revision Date: August 17, 2001** | **Page 1 of 8** |
| **PROVIDER CODE OF CONDUCT** | | |
| **RATIONALE: The purpose of this Provider Code of Conduct is to protect the clients of the Department of Human Services, to establish a consistent standard of conduct for the Providers who serve those clients, and to promote conduct that reflects respect for clients and others. (This policy incorporates the provisions of Rule 495-876.)** | | |

## I. STATEMENT OF PURPOSE.

The Department of Human Services ("DHS") adopts this Code of Conduct to:

(a) Protect its clients from abuse, neglect, maltreatment and exploitation; and

(b) Clarify the expectation of conduct for DHS Providers and their employees and volunteers who interact in any way with DHS clients, DHS staff and the public.

The Provider shall distribute a copy of this Code of Conduct to each employee and volunteer, regardless of whether the employees or volunteers provide direct care to clients, indirect care, administrative services or support services. The Provider shall require each employee and volunteer to read the Code of Conduct and sign a copy of the attached "Certificate of Understanding" before having any contact with DHS clients. The Provider shall file a copy of the signed Certificate of Understanding in each employee and volunteer's personnel file. The Provider shall also maintain a written policy that adequately addresses the appropriate treatment of clients and that prohibits the abuse, neglect, maltreatment or exploitation of clients. This policy shall also require the Provider's employees and volunteers to deal with DHS staff and the public with courtesy and professionalism.

This Code of Conduct supplements various statutes, policies and rules that govern the delivery of services to DHS clients. The Providers and the DHS Divisions or Offices may not adopt or enforce policies that are less stringent than this Code of Conduct unless those policies have first been approved in writing by the Office of Licensing and the Executive Director of the Utah Department of Human Services. Nothing in this Code of Conduct shall be interpreted to mean that clients are not accountable for their own misbehavior or inappropriate behavior, or that Providers are restricted from imposing appropriate sanctions for such behavior

## II. DEFINITIONS.

1. General Definitions:

**"Client"** means anyone who receives services either from DHS or from a Provider pursuant to an agreement with DHS or funding from DHS.

**"DHS"** means the Utah Department of Human Services or any of its divisions, offices or agencies.

**"Domestic-violence-related child abuse"** means any domestic violence or a violent physical or verbal interaction between cohabitants in the physical presence of a child or having knowledge that a child is present and may see or hear an act of domestic violence.

**"Emotional maltreatment"** means conduct that subjects the client to psychologically destructive behavior, and includes conduct such as making demeaning comments, threatening harm, terrorizing the client or engaging in a systematic process of alienating the client.

**"Provider"** means any individual or business entity that contracts with DHS or with a DHS contractor to provide services to DHS clients. The term "Provider" also includes licensed or certified individuals who provide services to DHS clients under the supervision or direction of a Provider. Where this Code of Conduct states (as in Sections III-VII) that the "Provider" shall comply with certain requirements and not engage in various forms of abuse, neglect, exploitation or maltreatment, the term "Provider" also refers to the Provider's employees, volunteers and subcontractors, and others who act on the Provider's behalf or under the Provider's control or supervision.

**"Restraint"** means the use of physical force or a mechanical device to restrict an individual's freedom of movement or an individual's normal access to his or her body. "Restraint" also includes the use of a drug that is not standard treatment for the individual and that is used to control the individual's behavior or to restrict the individual's freedom of movement.

**"Seclusion"** means the involuntary confinement of the individual in a room or an area where the individual is physically prevented from leaving.

**"Written agency policy,"** means written policy established by the Provider. If a written agency policy contains provisions that are more lenient than the provisions of this Code of Conduct, those provisions must be approved in writing by the DHS Executive Director and the Office of Licensing.

**B. Definitions of Prohibited Abuse, Neglect, Maltreatment and Exploitation:**

**"Abuse"** includes but is not limited to:

1. Harm or threatened harm to the physical or emotional health and welfare of a client.
2. Unlawful confinement.
3. Deprivation of life-sustaining treatment except in accordance with a valid advance directive or other legally-sufficient written directive from a competent client or the client's legal representative (e.g., a parent or legal guardian).
4. Physical injury, such as a contusion of the skin, laceration, malnutrition, burn, fracture of any bone, subdural hematoma, injury to any internal organ, any injury causing bleeding, or any physical condition which imperils a client's health or welfare.
5. Any type of unlawful hitting or corporal punishment.
6. Domestic-violence-related child abuse.

7. Any sexual abuse or sexual exploitation, including but not limited to:

   a. Engaging in sexual intercourse with any client.

   b. Touching the anus or any part of the genitals or otherwise taking indecent liberties with a client, or causing an individual to take indecent liberties with a client, with the intent to arouse or gratify the sexual desire of any person.

   c. Employing, using, persuading, inducing, enticing, or coercing a client to pose in the nude.

   d. Engaging a client as an observer or participant in sexual acts.

   e. Employing, using, persuading, inducing, enticing or coercing a client to engage in any sexual or simulated sexual conduct for the purpose of photographing, filming, recording, or displaying in any way the sexual or simulated sexual conduct. This includes displaying, distributing, possessing for the purpose of distribution, or selling material depicting nudity, or engaging in sexual or simulated sexual conduct with a client.

   f. Committing or attempting to commit acts of sodomy or molestation with a client.

      As used in this Code of Conduct, the terms Asexual abuse, and Asexual exploitation, do not refer to approved therapeutic processes used in the treatment of sexual deviancy or dysfunction as long as those therapeutic processes have been outlined in the client's treatment plan and are consistent with generally-accepted therapeutic practices and written agency policy.

"**Neglect**" includes but is not limited to:

1. Denial of sufficient nutrition.

2. Denial of sufficient sleep.

3. Denial of sufficient clothing, or bedding.

4. Failure to provide adequate client supervision, including situations where the Provider's employee or volunteer is asleep or ill on the job, or is impaired due to the use of alcohol or drugs.

5. Failure to provide care and treatment as prescribed by the client's service, program or treatment plan, including failure to arrange for medical or dental care or treatment as prescribed or as instructed by the client's physician or dentist, unless the client or the Provider obtains a second opinion from another physician or dentist, indicating that the originally-prescribed medical or dental care or treatment is unnecessary.

6. Denial of sufficient shelter, where shelter is part of the services the Provider is responsible for providing to the client.

7. Educational neglect (i.e., willful failure or refusal to make a good faith effort to ensure that a child in the Provider's care or custody receives an appropriate education).

**"Exploitation"** includes but is not limited to:

1. Using a client's property without the client's consent or using a client's property in a way that is contrary to the client's best interests, such as expending a client's funds for the benefit of another.

2. Making unjust or improper use of clients or their resources.

3. Accepting a gift in exchange for preferential treatment of a client or in exchange for services that the Provider is already obliged to provide to the client.

4. Using the labor of a client for personal gain.

5. Using the labor of a client without paying the client a fair wage or without providing the client with just or equivalent non-monetary compensation, except where such use is consistent with standard therapeutic practices and is authorized by DHS policy or the Provider's contract with DHS.

a. Examples:

(i) It is not "exploitation" for a foster parent to assign an extra chore to a foster child who has broken a household rule, because the extra chore is reasonable discipline and teaches the child to obey the household rules.

(ii) It is not "exploitation" to require clients to help serve a meal at a senior center where they receive free meals and are encouraged to socialize with other clients. The meal is a non-monetary compensation, and the interaction with other clients may serve the clients' therapeutic needs.

(iii) It is usually "exploitation" to require a client to provide extensive janitorial or household services without pay, unless the services are actually an integral part of the therapeutic program, such as in "clubhouse" type programs that have been approved by DHS.

**"Maltreatment"** includes but is not limited to:

1. Physical exercises, such as running laps or performing pushups, except where such exercises are consistent with an individual's service plan and written agency policy and with the individual's health and abilities.

2. Any form of Restraint or Seclusion used by the Provider for reasons of convenience or to coerce, discipline or retaliate against a client. The Provider may use a Restraint or Seclusion only in emergency situations where such use is necessary to ensure the safety of the client or others and where less restrictive interventions would be ineffective, and only if the use is authorized by the client's service plan and administered by trained authorized personnel. Any use of Restraint or Seclusion must end immediately once the emergency safety situation is resolved. The Provider shall comply with all applicable laws about Restraints or Seclusion, including all federal and state statutes, regulations, rules and policies.

3. Assignment of unduly physically strenuous or harsh work or exercise.

4. Requiring or forcing the client to take an uncomfortable position, such as squatting or bending, or requiring or forcing the client to repeat physical movements as a means of punishment.

5. Group punishments for misbehavior of individuals.

6. Emotional maltreatment, bullying, teasing, provoking or otherwise verbally or physically intimidating or agitating a client.

7. Denial of any essential program service solely for disciplinary purposes.

8. Denial of visiting or communication privileges with family or significant others solely for disciplinary purposes.

9. Requiring the individual to remain silent for long periods of time for the purpose of punishment.

10. Extensive withholding of emotional response or stimulation.

## III. ABUSE, NEGLECT, EXPLOITATION AND MALTREATMENT ARE PROHIBITED.

Providers shall not abuse, neglect, exploit or maltreat clients in any way, whether through acts or omissions or by encouraging others to act or by failing to deter others from acting.

## IV. PROVIDER'S COMPLIANCE WITH CONDUCT REQUIREMENTS IMPOSED BY LAW, CONTRACT OR OTHER POLICIES.

In addition to complying with this Code of Conduct, the Provider shall comply with all applicable laws (such as statutes, rules and court decisions) and all policies adopted by the DHS Office of Licensing, by the DHS Divisions or Offices whose clients the Provider serves, and by other state and federal agencies that regulate or oversee the Provider's programs. Where the Office of Licensing or another DHS entity has adopted a policy that is more specific or restrictive than this Code of Conduct, that policy shall control. If a statute, rule or policy defines abuse, neglect, exploitation or maltreatment as including conduct that is not expressly included in this Code of Conduct, such conduct shall also constitute a violation of this Code of Conduct. *See, e.g.*, Title 62A, Chapter 3 of the Utah Code (definition of adult abuse) and Title 78, Chapter 3a and Title 76, Chapter 5 of the Utah Code (definitions of child abuse).

## V. THE PROVIDER'S INTERACTIONS WITH DHS PERSONNEL AND THE PUBLIC.

In carrying out all DHS-related business, the Provider shall conduct itself with professionalism and shall treat DHS personnel, the members of the Provider's staff and members of the public courteously and fairly. The Provider shall not engage in criminal conduct or in any fraud or other financial misconduct.

## VI. SANCTIONS FOR NON-COMPLIANCE.

If a Provider or its employee or volunteer fail to comply with this Code of Conduct, DHS may impose appropriate sanctions (such as corrective action, probation, suspension, disbarment from State contracts, and termination of the Provider's license or certification) and may avail itself of all legal and equitable remedies (such as money damages and termination of the Provider's contract). In imposing such sanctions and remedies, DHS shall comply with the Utah Administrative Procedures Act and applicable DHS rules. In appropriate circumstances, DHS shall also report the Provider's misconduct to law enforcement and to the Provider's clients and their families or legal representatives (e.g., a legal guardian). In all cases, DHS shall also report the Provider's misconduct to the licensing authorities, including the DHS Office of Licensing.

## VII. PROVIDERS' DUTY TO HELP DHS PROTECT CLIENTS.

1. **Duty to Protect Clients' Health and Safety.** If the Provider becomes aware that a client has been subjected to any abuse, neglect, exploitation or maltreatment, the Provider's first duty is to protect the client's health and safety.

2. **Duty to Report Problems and Cooperate with Investigations.** Providers shall document and report any abuse, neglect, exploitation or maltreatment and exploitation as outlined in this Code of Conduct, and they shall cooperate fully in any investigation conducted by DHS, law enforcement or other regulatory or monitoring agencies.

   a. Except as provided in Section (B)(1)(a) and (B)(3) below, Providers shall immediately report abuse, neglect, exploitation or maltreatment by contacting the local Regional Office of the appropriate DHS Division or Office. During weekends and on holidays, Providers shall make such reports to the on-call worker of that Regional Office.

      (i) Providers shall report any abuse or neglect of disabled or elder adults to the Adult Protective Services intake office of the Division of Aging and Adult Services.

   b. The Provider shall make all reports and documentation about abuse, neglect, exploitation, and maltreatment available to appropriate DHS personnel and law enforcement upon request.

   c. Providers shall document any client injury (explained or unexplained) that occurs on the Providers' premises or while the client is under the Provider's care and supervision, and the Provider shall report any such injury to supervisory personnel immediately. Providers shall cooperate fully in any investigation conducted by DHS, law enforcement or other regulatory or monitoring agencies. If the client's injury is extremely minimal, the Provider has 12 hours to report the injury. The term "extremely minimal" refers to injuries that obviously do not require medical attention (beyond washing a minor wound and applying a band-aid, for example) and which cannot reasonably be expected to benefit from advice or consultation from the supervisory personnel or medical practitioners.

      (i) Example: If a foster child falls off a swing and skins her knee slightly, the foster parent shall document the injury and report to the foster care worker within 12 hours.

      (ii) Example: If a foster child falls off a swing and sprains or twists her ankle, the foster parent shall document the injury and report it immediately to supervisory personnel because the supervisor may want the child's ankle X-rayed or examined by a physician.

3. **Duty to Report Fatalities and Cooperate in Investigations and Fatality Reviews.** If a DHS client dies while receiving services from the Provider, the Provider shall notify the supervising DHS Division or Office immediately and shall cooperate with any investigation into the client's death. In addition, some Providers are subject to the Department of Human Services' Fatality Review Policy. (See the "Eligibility" section of DHS Policy No. 05-02 for a description of the entities subject to the fatal-review requirements. A copy of the policy is available at the DHS web site at: http://www.dhs.state.ut.us/policy.htm) If the Provider is subject to the Fatality Review Policy, it shall comply with that policy (including all reporting requirements) and the Provider shall cooperate fully with any fatality reviews and investigations concerning a client death.

4. **Duty to Display DHS Poster.** The Provider shall prominently display in each facility a DHS poster that notifies employees of their responsibilities to report violations of this Provider Code of Conduct, and that gives phone numbers for the Regional Office or Intake Office of the relevant DHS Division(s). Notwithstanding the foregoing, if the Provider provides its services in a private home and if the Provider has fewer than three employees or volunteers, the Provider shall maintain this information in a readily-accessible place but it need not actually display the DHS poster. DHS shall annually provide the Provider with a copy of the current DHS poster or it shall make the poster available on the DHS web site: http://www.dhs.state.ut.us.

Robin Arnold-Williams

DATE: 08-17-01

Robin Arnold-Williams, Executive Director
Department of Human Services

**PROVIDER CODE OF CONDUCT**
**CERTIFICATE OF UNDERSTANDING AND COMPLIANCE**
(To be signed by all DHS Providers and their employees, volunteers and subcontractors.)

I have read and been provided with a personal copy of the Provider Code of Conduct for the Utah Department of Human Services.

I understand this Code of Conduct and I will comply with it. I have had an opportunity to ask questions and seek clarification about the Code of Conduct, and my questions have been answered to my satisfaction and understanding.

_____

Signature of Employee or Volunteer Date

_____

Print Name

_____

Signature of Supervisor Date

_____

Print Name

_____

Program/Facility

_____

Street Address

_____

City, State, ZIP Code

**The Provider shall place a copy of this signed "Certificate of Understanding and Compliance" sheet in the signer's personnel file and shall make that file available to DHS upon request**.

UTAH DEPARTMENT OF HUMAN SERVICES

# PROVIDER CODE OF CONDUCT

## ANY CONTRACTED, LICENSED OR CERTIFIED AGENCY, INDIVIDUAL, OR EMPLOYEE IS RESPONSIBLE TO DOCUMENT AND REPORT ABUSE, SEXUAL ABUSE AND SEXUAL EXPLOITATION, NEGLECT, MALTREATMENT AND EXPLOITATION.

## IF YOU WITNESS PROVIDER CODE OF CONDUCT VIOLATIONS, CALL THE DEPARTMENT OF HUMAN SERVICES:

# 1-800-662-3722 (Statewide/toll free)

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### IF YOU WITNESS QUESTIONABLE FINANCIAL ACTIVITY, OR OTHER UNETHICAL BEHAVIOR

The information below will assist you in contacting the correct Department of Human Services office where you may submit your concerns or complaints or seek assistance in resolving a problem.

- For all issues related to facilities and operations or background screening please contact:
  - **DHS Office of Licensing - (801) 538-4242**

- If you have any concerns regarding treatment of clients please contact:
  - **Office of Child Protection Ombudsman – 1-800-868-6413**
  - **Disabilities Ombudsman – (801) 538-4373**

- For any concerns related to Department of Human Services contracts, (i.e., financial or payment issues, or to report suspected misuse of public funds) please contact:
  - **Office of Fiscal Operations – (801) 538-8261**

Revised 1/2004

# Form W-4 (2007)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds $850 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners/Multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

**Nonresident alien.** If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

| | | |
|---|---|---|
| A | Enter "1" for **yourself** if no one else can claim you as a dependent | A ____ |
| B | Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less. | B ____ |
| C | Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) | C ____ |
| D | Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return | D ____ |
| E | Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) | E ____ |
| F | Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | F ____ |
| G | **Child Tax Credit** (including additional child tax credit). See Pub 972, Child Tax Credit, for more information. • If your total income will be less than $57,000 ($85,000 if married), enter "2" for each eligible child. • If your total income will be between $57,000 and $84,000 ($85,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 or more eligible children. | G ____ |
| H | Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ | H ____ |

**For accuracy, complete all worksheets that apply.**

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

**Cut here and give Form W-4 to your employer. Keep the top part for your records.**

Form **W-4**

Department of the Treasury
Internal Revenue Service

## Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

**2007**

| | | |
|---|---|---|
| 1 Type or print your first name and middle initial. | Last name | 2 Your social security number |
| Home address (number and street or rural route) | 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. | |
| City or town, state, and ZIP code | 4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐ | |

| | | |
|---|---|---|
| 5 | Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | 5 |
| 6 | Additional amount, if any, you want withheld from each paycheck | 6 $ |
| 7 | I claim exemption from withholding for 2007, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶ | 7 |

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

**Employee's signature** (Form is not valid unless you sign it.) ▶ **Date** ▶

| | | |
|---|---|---|
| 8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) | 10 Employer identification number (EIN) |

## Deductions and Adjustments Worksheet

**Note.** Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2007 tax return.

1 Enter an estimate of your 2007 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2007, you may have to reduce your itemized deductions if your income is over $156,400 ($78,200 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . 1 $

2 Enter: { $10,700 if married filing jointly or qualifying widow(er) / $ 7,850 if head of household / $ 5,350 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2007 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919) . 5 $

6 Enter an estimate of your 2007 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $3,400 and enter the result here. Drop any fraction . . . . . 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . . . 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

## Two-Earners/Multiple Jobs Worksheet (See *Two earners/multiple jobs* on page 1.)

**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $50,000 or less, do not enter more than "3." . . . . . 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3

**Note.** If line 1 is *less than* line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4

5 Enter the number from line 1 of this worksheet . . . . . 5

6 **Subtract** line 5 from line 4 . . . . . 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2007. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2006. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $

### Table 1

| Married Filing Jointly | | All Others | |
|---|---|---|---|
| If wages from **LOWEST** paying job are— | Enter on line 2 above | If wages from **LOWEST** paying job are— | Enter on line 2 above |
| $0 - $4,500 | 0 | $0 - $6,000 | 0 |
| 4,501 - 9,000 | 1 | 6,001 - 12,000 | 1 |
| 9,001 - 18,000 | 2 | 12,001 - 19,000 | 2 |
| 18,001 - 22,000 | 3 | 19,001 - 26,000 | 3 |
| 22,001 - 26,000 | 4 | 26,001 - 35,000 | 4 |
| 26,001 - 32,000 | 5 | 35,001 - 50,000 | 5 |
| 32,001 - 38,000 | 6 | 50,001 - 65,000 | 6 |
| 38,001 - 46,000 | 7 | 65,001 - 80,000 | 7 |
| 46,001 - 55,000 | 8 | 80,001 - 90,000 | 8 |
| 55,001 - 60,000 | 9 | 90,001 - 120,000 | 9 |
| 60,001 - 65,000 | 10 | 120,001 and over | 10 |
| 65,001 - 75,000 | 11 | | |
| 75,001 - 95,000 | 12 | | |
| 95,001 - 105,000 | 13 | | |
| 105,001 - 120,000 | 14 | | |
| 120,001 and over | 15 | | |

### Table 2

| Married Filing Jointly | | All Others | |
|---|---|---|---|
| If wages from **HIGHEST** paying job are— | Enter on line 7 above | If wages from **HIGHEST** paying job are— | Enter on line 7 above |
| $0 - $65,000 | $510 | $0 - $35,000 | $510 |
| 65,001 - 120,000 | 850 | 35,001 - 80,000 | 850 |
| 120,001 - 170,000 | 950 | 80,001 - 150,000 | 950 |
| 170,001 - 300,000 | 1,120 | 150,001 - 340,000 | 1,120 |
| 300,001 and over | 1,190 | 340,001 and over | 1,190 |

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136

# Employment Eligibility Verification

## INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

**Anti-Discrimination Notice.** It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1 - Employee.** All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

**Preparer/Translator Certification.** The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1.

**Section 2 - Employer.** For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1)** document title; **2)** issuing authority; **3)** document number, **4)** expiration date, if any; and **5)** the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

**Section 3 - Updating and Reverification.** Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/ reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
  - examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
  - record the document title, document number and expiration date (if any) in Block C, and
  - complete the signature block.

**Photocopying and Retaining Form I-9.** A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

**For more detailed information, you may refer to the INS Handbook for Employers, (Form M-274). You may obtain the handbook at your local INS office.**

**Privacy Act Notice.** The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Naturalization Service, the Department of Labor and the Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

**Reporting Burden.** We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, 5 minutes; **2)** completing the form, 5 minutes; and **3)** assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to the Immigration and Naturalization Service, HQPDI, 425 I Street, N.W., Room 4034, Washington, DC 20536. OMB No. 1115-0136.

**EMPLOYERS MUST RETAIN COMPLETED FORM I-9**
**PLEASE DO NOT MAIL COMPLETED FORM I-9 TO INS**

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136

# Employment Eligibility Verification

**Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.**

## Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

| Print Name: Last | First | Middle Initial | Maiden Name |
|---|---|---|---|
| Address *(Street Name and Number)* | | Apt. # | Date of Birth *(month/day/year)* |
| City | State | Zip Code | Social Security # |

**I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.**

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A_____)
- ☐ An alien authorized to work until ___/___/___ (Alien # or Admission #) _____

Employee's Signature | Date *(month/day/year)*

### Preparer and/or Translator Certification.

*(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

## Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s)

| List A | OR | List B | AND | List C |
|---|---|---|---|---|
| Document title: _____ | | _____ | | _____ |
| Issuing authority: _____ | | _____ | | _____ |
| Document #: _____ | | _____ | | _____ |
| Expiration Date *(if any)*: ___/___/___ | | ___/___/___ | | ___/___/___ |
| Document #: _____ | | | | |
| Expiration Date *(if any)*: ___/___/___ | | | | |

**CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on** *(month/day/year)* ___/___/___ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name | Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

## Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)* | B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title:_____ Document #: _____ Expiration Date (if any): ___/___/___

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative | Date *(month/day/year)*

## LISTS OF ACCEPTABLE DOCUMENTS

**LIST A**

**Documents that Establish Both Identity and Employment Eligibility**

1. U.S. Passport (unexpired or expired)
2. Certificate of U.S. Citizenship *(INS Form N-560 or N-561)*
3. Certificate of Naturalization *(INS Form N-550 or N-570)*
4. Unexpired foreign passport, with *I-551 stamp or* attached *INS Form I-94* indicating unexpired employment authorization
5. Permanent Resident Card or Alien Registration Receipt Card with photograph *(INS Form I-151 or I-551)*
6. Unexpired Temporary Resident Card *(INS Form I-688)*
7. Unexpired Employment Authorization Card *(INS Form I-688A)*
8. Unexpired Reentry Permit *(INS Form I-327)*
9. Unexpired Refugee Travel Document *(INS Form I-571)*
10. Unexpired Employment Authorization Document issued by the INS which contains a photograph *(INS Form I-688B)*

**OR**

**LIST B**

**Documents that Establish Identity**

1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

**For persons under age 18 who are unable to present a document listed above:**

10. School record or report card
11. Clinic, doctor or hospital record
12. Day-care or nursery school record

**AND**

**LIST C**

**Documents that Establish Employment Eligibility**

1. U.S. social security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card *(INS Form I-197)*
6. ID Card for use of Resident Citizen in the United States *(INS Form I-179)*
7. Unexpired employment authorization document issued by the INS *(other than those listed under List A)*

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)**

Utah-DHS-OL
May 2007

Utah Department of Human Services Office of Licensing
120 North 200 West, #303 Salt Lake City, Utah 84103
BACKGROUND SCREENING APPLICATION

DSPD SAS

*******APPLICANT REQUEST AND RELEASE*******

I hereby authorize the Utah Department of Human Services Office of Licensing to investigate my past and present child and adult abuse, neglect and exploitation records, law enforcement, driver's license and any and all information which may be pertinent to my application according to Utah Code 62A-2-120, 121, 122, and Rule 501-14. The release of any and all information is authorized whether the same is of record or not. I do hereby release the Department of Human Services from any damages resulting from the Department of Human Services furnishing such information to authorized agencies.

**Incomplete/illegible applications or applications without a copy of a current valid state driver's license or state identification card issued by the Division of Motor Vehicles will be returned. Please use red, blue, purple or green ink (no black, light or pastel colors).**

Please answer the following questions:

1. Have you ever been charged with a crime by any law enforcement authority? ☐ Yes ☐ No
Disclose all criminal offenses even if they were later dismissed or you completed a plea in abeyance or diversion program whether you pled guilty or not guilty to an offense, or if you are waiting to enter a plea to the court. If yes, attach a certified court docket or other certified record indicating the disposition of each charge or offense, or the status of each plea in abeyance or diversion agreement.

2. In the last five years have you lived or spent **six (6) or more consecutive weeks** in a U.S. state besides Utah? ☐ Yes ☐ No
If yes, list each state separately: State:_____ FROM month/year:_____ TO month/year:_____

3. In the last five years have you lived or spent **six (6) or more consecutive weeks** in a foreign country or U.S. Territory other than the U.S.? See the instruction sheet for further direction. ☐ Yes ☐ No
If yes, list each country separately: Country:_____ FROM month/year:_____ TO month/year:_____

4. Are you the grandfather, grandmother, uncle, aunt, sibling, or child of the person to be served? ☐ Yes ☐ No
If yes, do not send fingerprint cards.

**If you answered yes to question 2, and no to question 4, you must submit two completed fingerprint cards with this form.**

If you do not have a middle name please write "Not Applicable" above the line for "Full Middle Name"

Full First Name_____ Full Middle Name_____ Last Name_____

All Maiden/Alias /Previous Married Names:_____

Current Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____/_____/_____ Social Security Number:_____-_____-_____ Phone:

I certify that my answers contain no misrepresentation or falsification, and that the information is true and complete to the best of my knowledge. I understand that providing false or inaccurate information or failing to provide information may result in my background screening being delayed or denied.

Enter client # for DSPD self-administered Direct Service Worker

Applicant Signature: _____ Date: _____ _____

********AGENCY/LICENSED PROGRAM REQUEST AND RELEASE********

This section to be completed by the Foster Care Licensor, or the authorized representative for the program or Agency. **Complete all fields. Incomplete or illegible applications will be returned.** Machine print or use red, blue, purple or green ink (no black, light or pastel colors).

Name of Agency, Licensee or DHS Licensor: **Division of Services for People with Disabilities** Phone number: **(801) 538-4476**

Address: **120 North 200 West, Room 411** City: **Salt Lake City** State: **Utah** Zip Code: **84103**

Does the applicant provide foster/proctor care services? ■ No **IF YES DO NOT USE THIS FORM**

I certify that I have inspected the applicant's state driver's license or state identification card, it does not appear to have been forged or altered, and it appears to be identical to the original. I have reviewed this completed application and it contains no misrepresentation or falsification to the best of my knowledge. The employer releases the Department of Human Services from any damages resulting from disclosing information to authorized agencies. The employer shall not disclose this form or its contents except as authorized by Utah or federal law.

_____ **Becky Dalby, DSPD Background Screening Tech**

Signature of Authorized Agency or Program Representative or DHS Licensor Printed Name of Authorized Agency or Program Representative or DHS Licensor

**DO NOT WRITE OR MARK BELOW. THIS SPACE IS FOR CBS USE ONLY. STAMPS BELOW DESIGNATE APPROVAL.**

| 62A-2-120 | LIC-C | MIS -A | Date Stamp |
|---|---|---|---|
| | | | |

Dear Person or Family Member acting as an Employer in our self-administered service program:

Please help us match you with your employee(s) by reviewing the information and updating incorrect information. Update incorrect information by crossing it out and writing the correct information. If no information is entered please complete each blank. Thank-you

Name of Person receiving Services: _____ ID#_____

Person's Address: _____

_____

Person's Phone Number_____

Name of Person to Contact if there are problems with the application:_____
Phone Number:_____

Email Address:_____
Employee Information

| Employee Name | Employee Hire Date | Employee Termination Date |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

Support Coordinator_____ Phone Number_____

Fiscal Agent (circle one) Morning Star Leonard Consulting Acumen

The completion of a background check is required for each employee you hire. If you fail to have an employee complete the background check as required by Statute through the DHS, Office of Licensing, your services will be terminated.

# FORMS SPECIFIC TO
# THE COMMUNITY SUPPORT WAIVER (CSW)

- Employment Agreement - Form 2-9EA

- Application for Certification - Form 2-9C

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**

# EMPLOYMENT AGREEMENT

**(For Use by Employees Participating in the Self-Administered Services)**

**PARTIES:** This Employment Agreement is between _____("EMPLOYER")
*(Name of Person/Person's Representative)*
AND ("EMPLOYEE")

Name: _____

Address: _____

SSN #: _____

EMPLOYEE has been retained to provide services to EMPLOYER. Identified below are the service(s) that the EMPLOYEE may be authorized and certified to provide at the direction of the EMPLOYER. Also listed below are the current rates of payment for authorized services.

| | | |
|---|---|---|
| ☐ | Chore Services (CH1) | $_____ per ¼ hour |
| ☐ | Companions Services (CO1)<br>OR, when appropriate | $_____ per ¼ hour<br>$_____ daily |
| ☐ | Family Training and Preparation (TF1) | $_____ per ¼ hour |
| ☐ | Homemaker Services (HS1) | $_____ per ¼ hour |
| ☐ | Personal Assistance (PA1)<br>OR, when appropriate | $_____ per ¼ hour<br>$_____ daily |
| ☐ | Respite care (RP1)<br>OR, when appropriate | $_____ per ¼ hour<br>$_____ daily |
| ☐ | Respite care (RP6) | $_____ daily |
| ☐ | Respite Group (RP7)<br>OR, when appropriate | $_____ per ¼ hour<br>$_____ daily |
| ☐ | Respite Group/room and board (RP8)<br>OR, when appropriate | $_____ per ¼ hour<br>$_____ daily |
| ☐ | Supported Living (SL1) | $_____ per ¼ hour |
| ☐ | Transportation (DTP) | $_____ per mile |

**As a condition of providing services under this Agreement, EMPLOYEE represents and/or agrees to the following:**

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**

# EMPLOYMENT AGREEMENT

**(For Use by Employees Participating in the Self-Administered Services)**

1. The EMPLOYEE is certified to provide limited services to EMPLOYER. (As per Application for Certification, Form 2-9C)

2. The EMPLOYEE shall be employed At-Will by the employer. Employment-At-Will means that the employee may quit at any time for any reason, just as the employer may discharge employee at any time for any or no reason. This At-Will status may not be altered on behalf of employer by any oral statement or promise by anyone.

3. EMPLOYEE shall comply with applicable Administrative Rule R539-5-4 as directed by the EMPLOYER and Division of Services for People with Disabilities (Division). In addition, the EMPLOYEES shall adhere to the terms in the Department of Human Services Code of Conduct (Attachment B). EMPLOYEES acknowledge and agree that the DIVISION reserves the right to change its Administrative Rule at any time for any reason.

4. EMPLOYEE shall adhere to the requirements and responsibilities outlined in the PERSON'S Support Strategies and Behavior Support Plan, if applicable. EMPLOYEEs shall review the prohibited Behavior Support procedures outlined in R539-3-10.

5. The EMPLOYEE rate of pay may change, due to availability of funds or services provided. Any additional hours of service an EMPLOYEE is asked to provide, outside this Agreement, are rendered under the EMPLOYER's personal authority, accountability, and full liability.

6. EMPLOYEES are required to complete a Background Screening Application annually.

7. EMPLOYEES are sixteen (16) years of age or older. (EMPLOYEES under the age of eighteen (18) must have a parent co-sign this Agreement).

8. EMPLOYEES must be (18) years of age or older to provide Transportation (DTP) or Supported Living (SL1) which includes transportation services or overnight services.

9. Valid Drivers License? Yes___ No____
   Employees without a valid Drivers license may not transport individuals in connection with their employment responsibilities.

**10.** The EMPLOYEE will sign and submit to the EMPLOYER, on a regular basis, accurate timesheets indicating services rendered, type of service, the date, and the exact number of service hours delivered (to the nearest ¼ hour when paid per ¼ hour). Services will be defined as "rendered" when the signed timesheet is agreed upon by the EMPLOYER and submitted to the Fiscal Agent. **No payment for services will be made that do not meet this definition.**

11. The EMPLOYEE is aware that funds used to pay the employee for services under this Agreement are public funds, and that any false information provided is Fraud and may subject the EMPLOYEE to criminal action, or to administrative sanctions and/or liability for repayment of any funds received.

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**

**EMPLOYMENT AGREEMENT**

**(For Use by Employees Participating in the Self-Administered Services)**

12. Except as may be prohibited by law, EMPLOYEES must promptly repay any overpayment to EMPLOYER, regardless of fault.

13. Worker's Compensation insurance IS / IS NOT (**Employer must circle one**) provided, under this Agreement.

14. Services the EMPLOYEE provides ARE/ARE NOT (**Employer must circle one)** Medicaid reimbursable services.

15. **When employed to provide care or services for which Medicaid reimbursement will be claimed, the EMPLOYEE must:**

    a) Be aware of and comply with all appropriate and applicable Medicaid policies and procedures, and state and federal rules and regulations in effect when services are rendered;

    b) Provide care and services as authorized by the assigned Support Coordinator in accordance with all applicable Medicaid regulations and policies;

    c) Complete accurate information on a timesheet for submission to the Fiscal Agent following the agent's payroll schedule.

    d) Not bill the employer or otherwise attempt to collect payment for services except as specifically permitted by Medicaid policy and accept payment or claims adjudication from the Department of Health, as the State Medicaid Agency, as payment in full for services rendered;

    e) Accept the status of independent contractor to the State Medicaid Agency without holding the Department of Health or the State of Utah to any agreement, settlement, liability or understanding whatsoever;

    f) Indemnify and hold harmless the Department of Health for any claims arising out of work performed by employee under authority of this agreement;

    g) Respect the person's confidentiality, refraining from disclosing information concerning the care or services given to the person receiving service except as specifically allowed by state and federal laws and regulations.

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**

# EMPLOYMENT AGREEMENT

**(For Use by Employees Participating in the Self-Administered Services)**

**I acknowledge that the Utah Department of Human Services, Division of Services for People with Disabilities does not require the EMPLOYER to provide any insurance coverage to compensate me if I am injured during the course of this employment. I also acknowledge that the Division (the State agency authorizing Medicaid services) is not responsible for the actions of EMPLOYER and will claim governmental immunity for any harm or damages that I may incur during the course of my employment pursuant to this Agreement.**

**By my signature, I certify that I have read and agree to be bound by the terms of this Agreement. I acknowledge that my failure to abide by this Agreement may result in the loss of employment with EMPLOYER. I further acknowledge either party, with or without cause, may terminate this Agreement at any time.**

| | |
|---|---|
| EMPLOYEE | DATE |
| EMPLOYEE'S PARENT OR GUARDIAN<br>*(Required if EMPLOYEE is under age 18)* | DATE |

# DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

## APPLICATION FOR CERTIFICATION TO PROVIDE LIMITED SERVICES TO AN INDIVIDUAL UNDER THE SELF-ADMINISTERED SERVICES

Name of Applicant: _____ Date: _____

Address: _____ Phone: _____

Name of Person Applicant Desires to Support: _____

Service(s) Applicant Desires to Provide (*Circle All Applicable Services)*: **CH1 (Q); HS1 (Q); DTP; RP1 (Q-D); RP6 (D); PA1 (Q-D); SL1 (Q); TF1 (Q); CO1 (Q-D); RP7 (Q-D); RP8 (Q-D)**

**Knowledge Requirements for Certification:**

Employment Agreement ☐ Date _____

Department of Human Services
Provider Code of Conduct ☐ Date _____

Incident Reporting ☐ Date: _____

Behavior Management ☐ Date _____
(If applicable)

**SIGNATURES:**

**I represent that I have read and am familiar with the above-identified materials and that I have been oriented to and/or trained on all of the materials by: _____on the dates indicated. I further represent that I both understand and will comply with the requirements identified in the materials in providing services to the Person and that I am capable of providing appropriate services to the Person.**

_____ _____

Signature of Applicant Date

**I, _____ represent that I am the Person, the Person's Representative, or the Person with a Designated Administrator of Supports for the Person and that I am familiar with both the above-identified materials and the supports required by the Person. I further represent that I provided orientation and/or training to the Applicant on all of the required materials on the dates indicated. I further represent that based on the training and orientation provided to the Applicant, I am satisfied the Applicant has the knowledge, understanding, and ability to provide appropriate services to the Person.**

_____ _____

**Signature of Person, Guardian, or Designated Administrator** Date

## AWARD OF CERTIFICATION TO PROVIDE LIMITED SERVICES TO AN INDIVIDUAL WITH MENTAL RETARDATION OR RELATED CONDITION RECEIVING SELF-ADMINISTERED SERVICES

Based on the forgoing representations of the Applicant and the Person, Person's Legal Guardian, or Person's Designated Administrator of Supports, the Applicant has met the minimum requirements necessary for Certification to Provide Limited Services to an Individual receiving Self-Administered Services. The Division, therefore, awards the Applicant certification to provide the following services *(circle those applicable)*:

**CH1(Q); HS1(Q); DTP; RP1 (Q-D); RP6 (D); PA1 (Q-D); SL1 (Q); TF1 (Q); CO1 (Q-D); RP7 (Q-D); RP8 (Q-D)**

to **(Name of person)**:_____.

_____ _____

Signature of Division Support Coordinator Date

# FORMS SPECIFIC TO
# THE ACQUIRED BRAIN INJURY WAIVER (ABIW)

- Employment Agreement - Form 2-9EA (B)

- Application for Certification - Form2-9C (B)

# DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

## EMPLOYMENT AGREEMENT

(For Use by Employee Participating in the Self-Administered Services)

**PARTIES:** This Employment Agreement is between _____( "EMPLOYER")
*(Name of Person/Person's Representative)*
AND ("EMPLOYEE")

Name: _____

Address: _____

SSN #: _____

EMPLOYEE has been retained to provide services to EMPLOYER. Identified below are the service(s) that the EMPLOYEE may be authorized and certified to provide at the direction of the EMPLOYER. Also listed below are the current rates of payment for authorized services.

| | | | |
|---|---|---|---|
| ☐ | Chore Services (CH1) | $_____ | ☐ per ¼ hour |
| ☐ | Daily Transportation Payment (DTP) | $_____ | per mile |
| ☐ | Homemaker (HS1) | $_____ | ☐ per ¼ hour |
| ☐ | Respite care (RP1) | $_____ | per ¼ hour |
| | OR, when appropriate | $_____ | daily |
| ☐ | Supported Living Hourly (SL1) | $_____ | ☐ per ¼ hour |

**As a condition of providing services under this Agreement, EMPLOYEE represents and/or agrees to the following:**

1. The EMPLOYEE is certified to provide limited services to EMPLOYER. (As per Application for Certification, Form 2-9C)

2. The EMPLOYEE shall be employed At-Will by the employer. Employment-At-Will means that the employee may quit at any time for any reason, just as the employer may discharge employee at any time for any or no reason. This At-Will status may not be altered on behalf of employer by any oral statement or promise by anyone.

3. EMPLOYEE shall comply with applicable Administrative Rule R539-5-4 as directed by the EMPLOYER and Division of Services for People with Disabilities (Division). In addition, the EMPLOYEES shall adhere to the terms in the Department of Human Services Code of Conduct (Attachment B). EMPLOYEES acknowledge and agree that the DIVISION reserves the right to change its Administrative Rule at any time for any reason.

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**

**EMPLOYMENT AGREEMENT**

(For Use by Employee Participating in the Self-Administered Services)

4. EMPLOYEE shall adhere to the requirements and responsibilities outlined in the PERSON'S Support Strategies and Behavior Support Plan, if applicable. EMPLOYEE shall review the prohibited Behavior Support procedures outlined in R539-3-10.

5. The EMPLOYEE rate of pay may change, due to availability of funds or services provided. Any additional hours of service an EMPLOYEE is asked to provide, outside this Agreement, are rendered under the EMPLOYER's personal authority, accountability, and full liability.

6. EMPLOYEES are required to complete a Background Screening Application annually.

7. EMPLOYEES are sixteen (16) years of age or older. (EMPLOYEES under the age of eighteen (18) must have a parent co-sign this Agreement).

8. EMPLOYEES must be (18) years of age or older to provide Transportation (DTP) or Supported Living (SL1) which includes transportation services or overnight services.

9. Valid Drivers License? Yes___ No____
Employees without a valid Drivers license may not transport individuals in connection with their employment responsibilities.

**10.** The EMPLOYEE will sign and submit to the EMPLOYER, on a regular basis, accurate timesheets indicating services rendered, type of service, the date, and the exact number of service hours delivered (to the nearest ¼ hour when paid per ¼ hour). Services will be defined as "rendered" when the signed timesheet is agreed upon by the EMPLOYER and submitted to the Fiscal Agent. **No payment for services will be made that do not meet this definition.**

11. The EMPLOYEE is aware that funds used to pay the employee for services under this Agreement are public funds, and that any false information provided is Fraud and may subject the EMPLOYEE to criminal action, or to administrative sanctions and/or liability for repayment of any funds received.

12. Except as may be prohibited by law, EMPLOYEES must promptly repay any overpayment to EMPLOYER, regardless of fault.

13. Worker's Compensation insurance IS/IS NOT (**Employer must circle one**) provided, under this Agreement.

14. Services the EMPLOYEE provides ARE/ARE NOT (**Employer must circle one)** Medicaid reimbursable services.

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**

**EMPLOYMENT AGREEMENT**

(For Use by Employee Participating in the Self-Administered Services)

15. **When employed to provide care or services for which Medicaid reimbursement will be claimed, the EMPLOYEE must:**

a. Be aware of and comply with all appropriate and applicable Medicaid policies and procedures, and state and federal rules and regulations in effect when services are rendered;

b. Provide care and services as authorized by the assigned Support Coordinator in accordance with all applicable Medicaid regulations and policies;

c. Complete accurate information on a timesheet for submission to the Fiscal Agent following the agent's payroll schedule.

d. Not bill the employer or otherwise attempt to collect payment for services except as specifically permitted by Medicaid policy and accept payment or claims adjudication from the Department of Health, as the State Medicaid Agency, as payment in full for services rendered;

e. Accept the status of independent contractor to the State Medicaid Agency without holding the Department of Health or the State of Utah to any agreement, settlement, liability or understanding whatsoever;

f. Indemnify and hold harmless the Department of Health for any claims arising out of work performed by employee under authority of this agreement;

g. Respect the person's confidentiality, refraining from disclosing information concerning the care or services given to the person receiving service except as specifically allowed by state and federal laws and regulations.

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**

# EMPLOYMENT AGREEMENT

(For Use by Employee Participating in the Self-Administered Services)

**I acknowledge that the Utah Department of Human Services, Division of Services for People with Disabilities does not require the EMPLOYER to provide any insurance coverage to compensate me if I am injured during the course of this employment. I also acknowledge that the Division (the State agency authorizing Medicaid services) is not responsible for the actions of EMPLOYER and will claim governmental immunity for any harm or damages that I may incur during the course of my employment pursuant to this Agreement.**

**By my signature, I certify that I have read and agree to be bound by the terms of this Agreement. I acknowledge that my failure to abide by this Agreement may result in the loss of employment with EMPLOYER. I further acknowledge either party, with or without cause, may terminate this Agreement at any time.**

_____ _____

EMPLOYEE DATE

_____ _____

EMPLOYEE'S PARENT OR GUARDIAN DATE
*(Required if EMPLOYEE is under age 18)*

# DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

## APPLICATION FOR CERTIFICATION TO PROVIDE LIMITED SERVICES
TO AN INDIVIDUAL UNDER THE SELF-ADMINISTERED SERVICES
ACQUIRED BRAIN INJURY WAIVER

Name of Applicant: _____ Date: _____

Address: _____ Phone: _____

Name of Person Applicant Desires to Support: _____

Service(s) Applicant Desires to Provide (*Circle All Applicable Services)* **CH1 (Q); DTP; HS1 (Q); RP1 (Q-D); SL1 (Q);**

**Knowledge Requirements for Certification:**

| | | |
|---|---|---|
| Employment Agreement | ☐ | Date _____ |
| Department of Human Services Provider Code of Conduct | ☐ | Date _____ |
| Emergency Contact Information | ☐ | Date _____ |
| Person's Support Book/Daily File | ☐ | Date: _____ |
| Service Specific Training (by employer) | ☐ | Date _____ |
| Behavior Management (if applicable) | ☐ | Date _____ |
| ABI Info Packet | ☐ | Date: _____ |

**SIGNATURES:**

**I represent that I have read and am familiar with the above-identified materials and that I have been oriented to and/or trained on all of the materials by: _____on the dates indicated. I further represent that I both understand and will comply with the requirements identified in the materials in providing services to the Person and that I am capable of providing appropriate services to the Person.**

_____ _____
Signature of Applicant Date

**I, _____ represent that I am the Person, the Person's Representative, or the Person with a Designated Administrator of Supports for the Person and that I am familiar with both the above-identified materials and the supports required by the Person. I further represent that I provided orientation and/or training to the Applicant on all of the required materials on the dates indicated. I further represent that based on the training and orientation provided to the Applicant, I am satisfied the Applicant has the knowledge, understanding, and ability to provide appropriate services to the Person.**

_____ _____
**Signature of Person, Guardian, or Designated Administrator** Date

## AWARD OF CERTIFICATION TO PROVIDE LIMITED SERVICES
TO AN INDIVIDUAL WITH ACQUIRED BRAIN INJURY RECEIVING SELF-ADMINISTERED SERVICES

Based on the forgoing representations of the Applicant and the Person, Person's Legal Guardian, or Person's Designated Administrator of Supports, the Applicant has met the minimum requirements necessary for Certification to Provide Limited Services to an Individual receiving Self-Administered Services. The Division, therefore, awards the Applicant certification to provide the following services *(circle those applicable)*:
**CH1 (Q); DTP; HS1 (Q); RP1 (Q-D); SL1 (Q);** to :_____.
**(Name of Person)**

_____ _____
Signature of Division Support Coordinator Date

# BLANK FORMS FOR THE DAILY FILE

## Required:

- Emergency Contact Information
- Support Strategies
- Incident Report Form
- Timesheet with comment area (found in Fiscal Agent Packet)

## Optional:

- Emergency Medical History
- Service Specific Training (required, but optional for the Daily File)
- Daily Notes
- Daily Medication Chart
- Employee Instructions for Equipment
- Employee Schedule/Calendar
- Monthly Summary (for your use)

# EMERGENCY CONTACT INFORMATION

**(Posted next to the main phone)**

**FOR EMERGENCY FIRE, POLICE AND MEDICAL ASSISTANCE**

## *CALL 911*

**THIS ADDRESS IS: _____**

**THIS PHONE NUMBER IS: _____**

**TYPE OF ASSISTANCE NEEDED IS: _____**

**HEALTH CARE INFORMATION:_____**

**Parent / Guardian:**
**Work #: _____**
**Cell #: _____**

**Parent / Guardian:**
**Work #: _____**
**Cell #: _____**

**Secondary Contact #1**

**Name: _____**
**Phone: _____**
**Address: _____**
**Relationship: _____**

**Secondary Contact #2**

**Name: _____**
**Phone: _____**
**Address: _____**
**Relationship: _____**

# Support Strategies

## for
## Self-Administered Services

(Updated annually by Employer)

**For:** _____
**Annual Meeting Date:** _____

**What is the Goal?** (what is needed or important to the person) _____
_____

**What is the Vision or Purpose of the Goal?** (what is hoped to be gained) _____
_____
_____

**When will these steps be followed?** _____

**Who will follow these steps?** _____

**Employees will support this goal by following these steps: (list)**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES



**FORM 1-8**

# INCIDENT REPORT FORM

| | | |
|---|---|---|
| PERSON'S ID: 0___ ___ ___ ___ ___ ___ ___ ___ | PERSON'S NAME: | |
| TODAY'S DATE: ____/____/____ MM DD YY | DATE INCIDENT STARTED: ____/____/____ MM DD YY | TIME INCIDENT STARTED: _____ AM/PM |
| YOUR NAME: | DATE INCIDENT ENDED: ____/____/____ MM DD YY | TIME INCIDENT ENDED: _____ AM/PM |
| YOUR TITLE: | YOUR PHONE NUMBER: ( ) | |
| PROVIDER NAME: | PROVIDER SITE ADDRESS: | City: |
| NUMBER OF PEOPLE INVOLVED (INCLUDING PERSON IN SERVICES LISTED ABOVE): | | |

**NAMES and ROLES OF OTHERS INVOLVED or WITH PERTINENT INFORMATION, INCLUDING HEALTH CARE PROVIDERS, IF ANY:**
***(DO NOT INCLUDE PERSON IN SERVICES LISTED ABOVE):***

| | |
|---|---|
| NAME: | ROLE: |
| NAME: | ROLE: |
| NAME: | ROLE: |
| WHERE DID INCIDENT TAKE PLACE? | ☐ Provider Site Listed Above ☐ Day Program ☐ School ☐ Friend's Home ☐ Relative's Home ☐ Other Location (Describe Briefly): |

**ACTION TAKEN?**

| | | |
|---|---|---|
| MEDICAL PROFESSIONAL NOTIFIED? | ☐ Yes ☐ No | Name: Title: Phone: |
| PERSON HOSPITALIZED? | ☐ Yes ☐ No | Hospital's Name: Phone: |
| POLICE NOTIFIED? | ☐ Yes ☐ No | Date: ____/____/____ Time:_____ AM / PM |
| APS or CPS NOTIFIED? | ☐ Yes ☐ No | Date: ____/____/____ Time: _____ AM / PM |

**TYPE OF INCIDENT?**

| | |
|---|---|
| ☐ **INJURY** | Who Was Injured? ☐ Person in Services ☐ Another/Other Person(s) in Services ☐ Staff ☐ Other:<br>Who caused the injury? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other:<br>Body part(s) injured:<br>Severity/Treatment: |
| ☐ **ABUSE** | Who was abused? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other:<br>Who caused the abuse? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other:<br>Type of Abuse/Exploitation: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Financial<br>Abuse was: ☐ Observed ☐ Suspected<br>Severity/Treatment: |
| ☐ **CRIMINAL ACT** | Type of Act: |
| ☐ **DRUG/ALCOHOL** | ☐ Incident ☐ Overdose<br>Drug/Alcohol involved:<br>Severity/Treatment: |
| ☐ **Med Error** *(Resulting in Medical Procedure)* | Medication(s) involved:<br>Severity/Treatment: |
| ☐ **Missing Person** | Date Last Seen: ____/____/____ Time Last Seen:_____ AM / PM<br>Where last seen?<br>Date Found/Returned: ____/____/____ Time Found/Returned:_____ AM / PM |
| ☐ **SEIZURE**[1] | Duration:<br>Brief Description of Event: |
| ☐ **RESTRAINT**[2] Authorized by:<br>Name:_____<br>Title:_____ | Cause: ☐ Aggression ☐ Self-Injurious Behavior (SIB) ☐ Other:<br>Number of Minutes Person was Restrained: |
| ☐ **Property Destruction**[2] | Item(s) Destroyed: Cost to repair/replace? $_____.____<br>Owner(s) of Item(s) destroyed: |
| ☐ **OTHER INCIDENT** | Please provide brief description: |

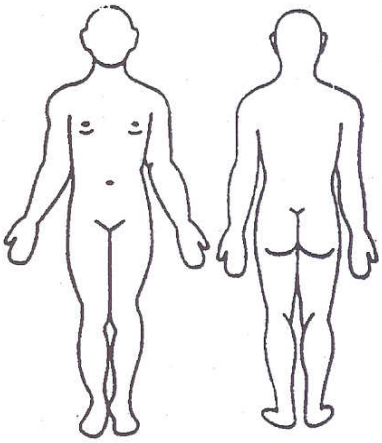
[1]If person has a diagnosis of Seizure Disorder, a monthly summary of seizures may be used instead of this form.
[2]If person destroys property or is restrained more than once a month, a monthly summary of incidents may be used instead of this form.

**INCIDENT REPORT FORM**

**FORM 1-8**

**Describe Incident in Detail;**
**Include How Each Person Was Involved:**

**Please mark the body parts injured**



| **Provider Signature:** | **Title:** |
|---|---|

**Support Coordinator Recommendation / Follow-Up:**
*(Attach APS or CPS Referral Sheet and Final Outcome of Investigation)*

| **Support Coordinator Signature:** | **Date Notified:** | **Today's Date:** |
|---|---|---|

# EMERGENCY MEDICAL HISTORY

This form is for Emergency use when Parent/Guardian/Representative is not immediately available but the individual needs emergency medical assistance. **For use by Emergency Personnel Only.**

**NAME: _____ Nickname: _____**
**Birth Date: _____**
**Home Address: _____ Home/Work Phone: _____**
**Parent/Guardian: _____ Address: _____**
**Phone Numbers: _____**
**Primary Language: _____**

**EMERGENCY CONTACT NAMES, RELATIONSHIP AND PHONE NUMBERS:**
**#1** _____
**#2** _____
**#3** _____

## Physicians

Primary Care Physician: _____
Emergency Phone: _____ Fax: _____

Current Specialty Physician: _____
Specialty: _____
Emergency Phone: _____ Fax: _____

Current Specialty Physician: _____
Specialty: _____
Emergency Phone: _____ Fax: _____

## Short Medical History

Diagnosis: _____
Current Medications (Name, Dose, Frequency given):_____
ALLERGIES (Drug):
_____
_____
_____

ALLERGIES (Food):
_____
_____
_____

Latex Allergy: Yes _____ No _____

Past Procedures (Procedure, Date, Facility):

Procedures to Avoid (and Why):

Prostheses/Appliances/Advanced Technology Devices:

Notes:

Division of Services for People with Disabilities

# Service Specific Training
## (Direct Service Training)
## Self-Administered

**Date:**_____
**For:** _____ **Prepared by:**_____

**Important information to know when providing direct services.**

1. **Medication Taken**

| Medication Name | Purpose | Possible Side Effects |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

1. **Instructions for supporting medication:**

_____
_____
_____

3. **Physical needs** (list any illness, diagnosis, etc. the employee should be aware of when supporting the person)**:**

_____
_____
_____

4. **Dietary concerns or allergies** (note item and reaction)**:**

5. **Important health needs:**

6. **Special instructions for eating or swallowing:**

7. **Note age appropriate community activities and natural supports that are important to the person:** (Age appropriate refers to activities that are similar to what peers at the same age may enjoy.)

8. **Things the person likes:**

9. **Physical limitations and concerns or equipment needs:** (Refer to the How to Use Equipment form if needed.)

10. **Discuss how the person's preferred recreational and leisure activities can be developed:** (This may be included on the Support Strategy.)

# DAILY NOTES

**Date:**

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# DAILY MEDICATION CHART

## Person's Name: _____

| Date | Medication | Dose/Route | Time Given | Reaction | Note | Employee Signature |
|---|---|---|---|---|---|---|
| | | | | | | |
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**Allergies:**

_____

_____

# Employee Instructions for Equipment

| Equipment | Instructions |
|---|---|
| **Item:** | |
| **Item:** | |
| **Item:** | |
| **Item:** | |
| **Item:** | |

# Employee Schedule / Calendar

Month / Year: _____
Employee: _____

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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# Monthly Summary

## for
## Self-Administered Services

(Information due to the Support Coordinator by the 15th of the month following services)

**For:** _____
**Month/yr**: _____

Please provide a summary of progress of each goal. (For each goal, describe the support given, how successful the support was and if this continues to meet the needs of the person receiving the service) Use back if necessary.

**Goal**: _____

**Summary**:
_____
_____
_____
_____

**Goal**: _____

**Summary**:
_____
_____
_____

**Health Concerns**: **Stable** _____ **Increased**_____ D**ecreased**_____

**Comments:** _____
_____

**Revisions of Service Needed**: Yes / No _____

**Additional Comments**: _____
_____

Employer Signature_____ Date: _____

# CURRENT DOCUMENTS

Keep the following documents in this section for 2 years. Refer to them as needed to understand your agreement and the services you are using. Documents older than 2 years need to be kept in the File Cabinet (long term maintenance) for 5 years.

- Service Agreement - Form 2-9SA (signed by you and your Support Coordinator)

- Individual Service Plan (ISP) including the Action Plan and Budget

# SECTION 4
# Employee Training and Orientation

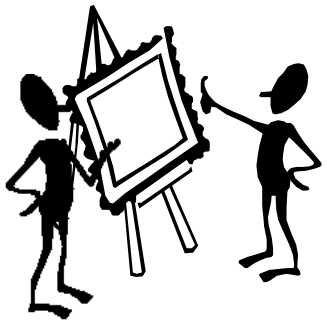
## Purpose

This Section, the Daily File, and the Fiscal Agent packet cover information for you to complete and understand with your employer prior to working unsupervised.

The person you serve has a Support Coordinator who identifies services and monitors that the person's needs are being met. The Support Coordinator is available to help you and your employer to understand your role and responsibilities.

## This Section Includes:

- Role and Responsibilities of the Employee
- Employee Training Requirements
- How to Complete and Submit a Timesheet
- Who to Contact for Help
- Employee Annual Requirements (Red tab)



# ROLE AND RESPONSIBILITIES OF THE EMPLOYEE

You have been hired to provide direct service and supervision to a person receiving services through the Division of Services for People with Disabilities. You are responsible to become familiar with the person's specific services and goals and complete all required training with your employer.

## Employee Responsibilities:

- Complete all required training included in this Section, the Daily File and the Fiscal Agent Packet prior to working with the person unsupervised.
- Provide supports and services outlined on the Support Strategy prepared by your employer.
- Complete payroll training including:
  - Filling-out timecards
  - Timesheet comments
  - Knowledge of pay periods

- Practice ethical behavior at all times as outlined in the Code of Conduct.
- Understand "At-Will" employment, which means that you or your employer may terminate employment with little or no advanced notice. Please make all efforts to work together to resolve any issues.
- Notify your employer immediately if any problem occurs with the person you serve (refer to the incident report form).
- Share important information to develop future goals and services.

# EMPLOYEE TRAINING REQUIREMENTS
## Complete with Employer

**Employer Tip:** *Have this Section 4 - Employee Training and Orientation, the Daily File, and a Fiscal Agent Packet ready as you prepare to train your employee.*

## Complete Training in the Following Areas with Your Employer:

- **Section 4 – Employee Training and Orientation.** Read all materials in this section.

  **Note important items below:**
  - Application for Certification - Form 2-9C(B) (provided in the Fiscal Agent Packet). Complete all areas identified and indicate Knowledge of Requirements for Certification by signing and dating each area completed.

  - Department Provider Code of Conduct. Read completely and sign the signature sheet.

- **Daily File.** Review contents and know where the Daily File will be kept for your daily use.

  A Daily File provides "KEY" information. The following items are required and will be included in the Daily File. Your employer may add additional items to help you best support their family member.

| Daily File Items | Purpose |
|---|---|
| Current Support Strategy | This is an outline of activities or steps to be addressed during your shift to help you support the person to achieve their goals. Support Strategies are updated annually. Think of this as your job description. |
| Timesheets | Each time you work, you will record the time you start and end your shift and enter the service you provide. You are required to make a brief comment of the activity you provide on the timesheet. Please be brief, clear and precise, it's a small area. |
| Emergency Information | Quick reference information including the person's address and contact information. Your employer may also post this near a phone. |
| Incident Report Forms | This is a report that is to be completed if certain events occur during your shift. Inform your employer of any situation that is listed on the description for completing an incident report as soon as possible. |

- **Fiscal Agent Packet.** Your employer works with a Fiscal Agent who receives and reviews your timesheets for correct billing practices, deducts taxes and pays you following a Payroll Schedule.

  **Complete Packet including**:

  - W-4
  - I-9 Employee Eligibility Verification Form. (There are two sections that need to be completed by you and your employer) Include copies of 2 forms of ID. See reverse side of I-9 for the list of accepted documentation and further instructions.

- Employment Agreement (form 2-9EA). Read and sign with your employer.

## Send the above three items to the Fiscal Agent

- Background Screening Application (BSA)
  Fully complete and include a copy of a Utah driver's license or State picture ID, and fingerprint cards if necessary. Send to:

**Division of Services for People with Disabilities**
**Attention: BSA**
**120 N. 200 W. #411**
**Salt Lake City, UT 84103**

- Review the timesheet format with your employer including comment area.
- Request a copy of the Payroll Schedule that explains when timesheets are due and when you can expect to be paid.

- **The following points have been made by people with disabilities who advocate for themselves and others:**

    - Take time to know the person
    - Let people do for themselves what they can
    - Talk to the person you support
    - Allow people time to respond and make choices
    - Ask the person, not just others who support them
    - Be respectful of who people are, their time and their home
    - Validate and support the interests of the person
    - Encourage independence
    - Understand the supports needed by the person so they can be safe and healthy while enjoying personal interests
    - Become familiar with "People First Language"

| DEPARTMENT OF HUMAN SERVICES<br>POLICY AND PROCEDURES | | |
|---|---|---|
| **Reference: 05-03** | **Effective Date: May 23, 1989**<br>**Revision Date: August 17, 2001** | **Page 1 of 8** |
| **PROVIDER CODE OF CONDUCT** | | |
| **RATIONALE: The purpose of this Provider Code of Conduct is to protect the clients of the Department of Human Services, to establish a consistent standard of conduct for the Providers who serve those clients, and to promote conduct that reflects respect for clients and others. (This policy incorporates the provisions of Rule 495-876.)** | | |

## I. STATEMENT OF PURPOSE.

The Department of Human Services ("DHS") adopts this Code of Conduct to:

(a) Protect its clients from abuse, neglect, maltreatment and exploitation; and

(b) Clarify the expectation of conduct for DHS Providers and their employees and volunteers who interact in any way with DHS clients, DHS staff and the public.

The Provider shall distribute a copy of this Code of Conduct to each employee and volunteer, regardless of whether the employees or volunteers provide direct care to clients, indirect care, administrative services or support services. The Provider shall require each employee and volunteer to read the Code of Conduct and sign a copy of the attached "Certificate of Understanding" before having any contact with DHS clients. The Provider shall file a copy of the signed Certificate of Understanding in each employee and volunteer's personnel file. The Provider shall also maintain a written policy that adequately addresses the appropriate treatment of clients and that prohibits the abuse, neglect, maltreatment or exploitation of clients. This policy shall also require the Provider's employees and volunteers to deal with DHS staff and the public with courtesy and professionalism.

This Code of Conduct supplements various statutes, policies and rules that govern the delivery of services to DHS clients. The Providers and the DHS Divisions or Offices may not adopt or enforce policies that are less-stringent than this Code of Conduct unless those policies have first been approved in writing by the Office of Licensing and the Executive Director of the Utah Department of Human Services. Nothing in this Code of Conduct shall be interpreted to mean that clients are not accountable for their own misbehavior or inappropriate behavior, or that Providers are restricted from imposing appropriate sanctions for such behavior

## II. DEFINITIONS.

1. General Definitions:

**"Client"** means anyone who receives services either from DHS or from a Provider pursuant to an agreement with DHS or funding from DHS.

**"DHS"** means the Utah Department of Human Services or any of its divisions, offices or agencies.

**"Domestic-violence-related child abuse"** means any domestic violence or a violent physical or verbal interaction between cohabitants in the physical presence of a child or having knowledge that a child is present and may see or hear an act of domestic violence.

**"Emotional maltreatment"** means conduct that subjects the client to psychologically destructive behavior, and includes conduct such as making demeaning comments, threatening harm, terrorizing the client or engaging in a systematic process of alienating the client.

**"Provider"** means any individual or business entity that contracts with DHS or with a DHS contractor to provide services to DHS clients. The term "Provider" also includes licensed or certified individuals who provide services to DHS clients under the supervision or direction of a Provider. Where this Code of Conduct states (as in Sections III-VII) that the "Provider" shall comply with certain requirements and not engage in various forms of abuse, neglect, exploitation or maltreatment, the term "Provider" also refers to the Provider's employees, volunteers and subcontractors, and others who act on the Provider's behalf or under the Provider's control or supervision.

**"Restraint"** means the use of physical force or a mechanical device to restrict an individual's freedom of movement or an individual's normal access to his or her body. "Restraint" also includes the use of a drug that is not standard treatment for the individual and that is used to control the individual's behavior or to restrict the individual's freedom of movement.

**"Seclusion"** means the involuntary confinement of the individual in a room or an area where the individual is physically prevented from leaving.

**"Written agency policy,"** means written policy established by the Provider. If a written agency policy contains provisions that are more lenient than the provisions of this Code of Conduct, those provisions must be approved in writing by the DHS Executive Director and the Office of Licensing.

**B. Definitions of Prohibited Abuse, Neglect, Maltreatment and Exploitation:**

**"Abuse"** includes but is not limited to:

1. Harm or threatened harm to the physical or emotional health and welfare of a client.

2. Unlawful confinement.

3. Deprivation of life-sustaining treatment except in accordance with a valid advance directive or other legally-sufficient written directive from a competent client or the client's legal representative (e.g., a parent or legal guardian).

4. Physical injury, such as a contusion of the skin, laceration, malnutrition, burn, fracture of any bone, subdural hematoma, injury to any internal organ, any injury causing bleeding, or any physical condition which imperils a client's health or welfare.

5. Any type of unlawful hitting or corporal punishment.

6. Domestic-violence-related child abuse.

**7. Any sexual abuse or sexual exploitation, including but not limited to:**

a. Engaging in sexual intercourse with any client.

b. Touching the anus or any part of the genitals or otherwise taking indecent liberties with a client, or causing an individual to take indecent liberties with a client, with the intent to arouse or gratify the sexual desire of any person.

c. Employing, using, persuading, inducing, enticing, or coercing a client to pose in the nude.

d. Engaging a client as an observer or participant in sexual acts.

e. Employing, using, persuading, inducing, enticing or coercing a client to engage in any sexual or simulated sexual conduct for the purpose of photographing, filming, recording, or displaying in any way the sexual or simulated sexual conduct. This includes displaying, distributing, possessing for the purpose of distribution, or selling material depicting nudity, or engaging in sexual or simulated sexual conduct with a client.

f. Committing or attempting to commit acts of sodomy or molestation with a client.

As used in this Code of Conduct, the terms Asexual abuse, and Asexual exploitation, do not refer to approved therapeutic processes used in the treatment of sexual deviancy or dysfunction as long as those therapeutic processes have been outlined in the client's treatment plan and are consistent with generally-accepted therapeutic practices and written agency policy.

**"Neglect"** includes but is not limited to:

1. Denial of sufficient nutrition.

2. Denial of sufficient sleep.

3. Denial of sufficient clothing, or bedding.

4. Failure to provide adequate client supervision, including situations where the Provider's employee or volunteer is asleep or ill on the job, or is impaired due to the use of alcohol or drugs.

5. Failure to provide care and treatment as prescribed by the client's service, program or treatment plan, including failure to arrange for medical or dental care or treatment as prescribed or as instructed by the client's physician or dentist, unless the client or the Provider obtains a second opinion from another physician or dentist, indicating that the originally-prescribed medical or dental care or treatment is unnecessary.

6. Denial of sufficient shelter, where shelter is part of the services the Provider is responsible for providing to the client.

7. Educational neglect (i.e., willful failure or refusal to make a good faith effort to ensure that a child in the Provider's care or custody receives an appropriate education).

**"Exploitation"** includes but is not limited to:

1. Using a client's property without the client's consent or using a client's property in a way that is contrary to the client's best interests, such as expending a client's funds for the benefit of another.

2. Making unjust or improper use of clients or their resources.

3. Accepting a gift in exchange for preferential treatment of a client or in exchange for services that the Provider is already obliged to provide to the client.

4. Using the labor of a client for personal gain.

5. Using the labor of a client without paying the client a fair wage or without providing the client with just or equivalent non-monetary compensation, except where such use is consistent with standard therapeutic practices and is authorized by DHS policy or the Provider's contract with DHS.

a. Examples:

(i) It is not "exploitation" for a foster parent to assign an extra chore to a foster child who has broken a household rule, because the extra chore is reasonable discipline and teaches the child to obey the household rules.

(ii) It is not "exploitation" to require clients to help serve a meal at a senior center where they receive free meals and are encouraged to socialize with other clients. The meal is a non-monetary compensation, and the interaction with other clients may serve the clients' therapeutic needs.

(iii) It is usually "exploitation" to require a client to provide extensive janitorial or household services without pay, unless the services are actually an integral part of the therapeutic program, such as in "clubhouse" type programs that have been approved by DHS.

**"Maltreatment"** includes but is not limited to:

1. Physical exercises, such as running laps or performing pushups, except where such exercises are consistent with an individual's service plan and written agency policy and with the individual's health and abilities.

2. Any form of Restraint or Seclusion used by the Provider for reasons of convenience or to coerce, discipline or retaliate against a client. The Provider may use a Restraint or Seclusion only in emergency situations where such use is necessary to ensure the safety of the client or others and where less restrictive interventions would be ineffective, and only if the use is authorized by the client's service plan and administered by trained authorized personnel. Any use of Restraint or Seclusion must end immediately once the emergency safety situation is resolved. The Provider shall comply with all applicable laws about Restraints or Seclusion, including all federal and state statutes, regulations, rules and policies.

3. Assignment of unduly physically strenuous or harsh work or exercise.

4. Requiring or forcing the client to take an uncomfortable position, such as squatting or bending, or requiring or forcing the client to repeat physical movements as a means of punishment.

5. Group punishments for misbehavior of individuals.

6. Emotional maltreatment, bullying, teasing, provoking or otherwise verbally or physically intimidating or agitating a client.

7. Denial of any essential program service solely for disciplinary purposes.

8. Denial of visiting or communication privileges with family or significant others solely for disciplinary purposes.

9. Requiring the individual to remain silent for long periods of time for the purpose of punishment.

10. Extensive withholding of emotional response or stimulation.

11. Denying a current client from entering the client's residence, where such denial is for disciplinary or retaliatory purposes or for any purpose unrelated to the safety of clients or others.

## III. ABUSE, NEGLECT, EXPLOITATION AND MALTREATMENT ARE PROHIBITED.

**Providers shall not abuse, neglect, exploit or maltreat clients in any way, whether through acts or omissions or by encouraging others to act or by failing to deter others from acting.**

## IV. PROVIDER'S COMPLIANCE WITH CONDUCT REQUIREMENTS IMPOSED BY LAW, CONTRACT OR OTHER POLICIES.

In addition to complying with this Code of Conduct, the Provider shall comply with all applicable laws (such as statutes, rules and court decisions) and all policies adopted by the DHS Office of Licensing, by the DHS Divisions or Offices whose clients the Provider serves, and by other state and federal agencies that regulate or oversee the Provider's programs. Where the Office of Licensing or another DHS entity has adopted a policy that is more specific or restrictive than this Code of Conduct, that policy shall control. If a statute, rule or policy defines abuse, neglect, exploitation or maltreatment as including conduct that is not expressly included in this Code of Conduct, such conduct shall also constitute a violation of this Code of Conduct. *See, e.g.,* Title 62A, Chapter 3 of the Utah Code (definition of adult abuse) and Title 78, Chapter 3a and Title 76, Chapter 5 of the Utah Code (definitions of child abuse).

## V. THE PROVIDER'S INTERACTIONS WITH DHS PERSONNEL AND THE PUBLIC.

In carrying out all DHS-related business, the Provider shall conduct itself with professionalism and shall treat DHS personnel, the members of the Provider's staff and members of the public courteously and fairly. The Provider shall not engage in criminal conduct or in any fraud or other financial misconduct.

## VI. SANCTIONS FOR NON-COMPLIANCE.

If a Provider or its employee or volunteer fail to comply with this Code of Conduct, DHS may impose appropriate sanctions (such as corrective action, probation, suspension, disbarment from State contracts, and termination of the Provider's license or certification) and may avail itself of all legal and equitable remedies (such as money damages and termination of the Provider's contract). In imposing such sanctions and remedies, DHS shall comply with the Utah Administrative Procedures Act and applicable DHS rules. In appropriate circumstances, DHS shall also report the Provider's misconduct to law enforcement and to the Provider's clients and their families or legal representatives (e.g., a legal guardian). In all cases, DHS shall also report the Provider's misconduct to the licensing authorities, including the DHS Office of Licensing.

## VII. PROVIDERS' DUTY TO HELP DHS PROTECT CLIENTS.

1. **Duty to Protect Clients' Health and Safety.** If the Provider becomes aware that a client has been subjected to any abuse, neglect, exploitation or maltreatment, the Provider's first duty is to protect the client's health and safety.

2. **Duty to Report Problems and Cooperate with Investigations.** Providers shall document and report any abuse, neglect, exploitation or maltreatment and exploitation as outlined in this Code of Conduct, and they shall cooperate fully in any investigation conducted by DHS, law enforcement or other regulatory or monitoring agencies.

a. Except as provided in Section (B)(1)(a) and (B)(3) below, Providers shall immediately report abuse, neglect, exploitation or maltreatment by contacting the local Regional Office of the appropriate DHS Division or Office. During weekends and on holidays, Providers shall make such reports to the on-call worker of that Regional Office.

(i) Providers shall report any abuse or neglect of disabled or elder adults to the Adult Protective Services intake office of the Division of Aging and Adult Services.

b. The Provider shall make all reports and documentation about abuse, neglect, exploitation, and maltreatment available to appropriate DHS personnel and law enforcement upon request.

c. Providers shall document any client injury (explained or unexplained) that occurs on the Providers' premises or while the client is under the Provider's care and supervision, and the Provider shall report any such injury to supervisory personnel immediately. Providers shall cooperate fully in any investigation conducted by DHS, law enforcement or other regulatory or monitoring agencies. If the client's injury is extremely minimal, the Provider has 12 hours to report the injury. The term "extremely minimal" refers to injuries that obviously do not require medical attention (beyond washing a minor wound and applying a band-aid, for example) and which cannot reasonably be expected to benefit from advice or consultation from the supervisory personnel or medical practitioners.

(i) Example: If a foster child falls off a swing and skins her knee slightly, the foster parent shall document the injury and report to the foster care worker within 12 hours.

(ii) Example: If a foster child falls off a swing and sprains or twists her ankle, the foster parent shall document the injury and report it immediately to supervisory personnel because the supervisor may want the child's ankle X-rayed or examined by a physician.

3. **Duty to Report Fatalities and Cooperate in Investigations and Fatality Reviews.** If a DHS client dies while receiving services from the Provider, the Provider shall notify the supervising DHS Division or Office immediately and shall cooperate with any investigation into the client's death. In addition, some Providers are subject to the Department of Human Services' Fatality Review Policy. (See the "Eligibility" section of DHS Policy No. 05-02 for a description of the entities subject to the fatal-review requirements. A copy of the policy is available at the DHS web site at: http://www.dhs.state.ut.us/policy.htm ) If the Provider is subject to the Fatality Review Policy, it shall comply with that policy (including all reporting requirements) and the Provider shall cooperate fully with any fatality reviews and investigations concerning a client death.

4. **Duty to Display DHS Poster.** The Provider shall prominently display in each facility a DHS poster that notifies employees of their responsibilities to report violations of this Provider Code of Conduct, and that gives phone numbers for the Regional Office or Intake Office of the relevant DHS Division(s). Notwithstanding the foregoing, if the Provider provides its services in a private home and if the Provider has fewer than three employees or volunteers, the Provider shall maintain this information in a readily-accessible place but it need not actually display the DHS poster. DHS shall annually provide the Provider with a copy of the current DHS poster or it shall make the poster available on the DHS web site: http://www.dhs.state.ut.us.

Robin Arnold-Williams

DATE: 08-17-01

Robin Arnold-Williams, Executive Director
Department of Human Services

Request this form from your employer

**PROVIDER CODE OF CONDUCT**
**CERTIFICATE OF UNDERSTANDING AND COMPLIANCE**

*(To be signed by all DHS Providers and their employees, volunteers and subcontractors.)*

I have read and been provided with a personal copy of the Provider Code of Conduct for the Utah Department of Human Services.

I understand this Code of Conduct and I will comply with it. I have had an opportunity to ask questions and seek clarification about the Code of Conduct, and my questions have been answered to my satisfaction and understanding.

_____

Signature of Employee or Volunteer Date

_____

Print Name:

_____

Signature of Supervisor Date

_____

Print Name:

_____

Program/Facility

_____

Street Address

_____

City, State, ZIP Code

**The Provider shall place a copy of this signed "Certificate of Understanding and Compliance" in the signer's personnel file and shall make that file available to DHS upon request**.

**UTAH DEPARTMENT OF HUMAN SERVICES**

# PROVIDER CODE OF CONDUCT

## ANY CONTRACTED, LICENSED OR CERTIFIED AGENCY, INDIVIDUAL, OR EMPLOYEE IS RESPONSIBLE TO DOCUMENT AND REPORT ABUSE, SEXUAL ABUSE AND SEXUAL EXPLOITATION, NEGLECT, MALTREATMENT AND EXPLOITATION.

## IF YOU WITNESS PROVIDER CODE OF CONDUCT VIOLATIONS, CALL THE DEPARTMENT OF HUMAN SERVICES:

# 1-800-662-3722 (Statewide/toll free)

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### IF YOU WITNESS QUESTIONABLE FINANCIAL ACTIVITY, OR OTHER UNETHICAL BEHAVIOR

The information below will assist you in contacting the correct Department of Human Services office where you may submit your concerns or complaints or seek assistance in resolving a problem.

- For all issues related to facilities and operations or background screening please contact:
  - **DHS Office of Licensing - (801) 538-4242**

- If you have any concerns regarding treatment of clients please contact:
  - **Office of Child Protection Ombudsman – 1-800-868-6413**
  - **Disabilities Ombudsman – (801) 538-4373**

- For any concerns related to Department of Human Services contracts, (i.e., financial or payment issues, or to report suspected misuse of public funds) please contact:
  - **Office of Fiscal Operations – (801) 538-8261**

Revised 1/2004

you would use for a person.

# People First Language

What Do You Call People with Disabilities? Men, women, boys, girls, students, mom, Sue's brother, Mr. Smith, Rosita, a neighbor, employer, coworker, customer, chef, teacher, scientist, athlete, adults, children, tourists, retirees, actors, comedians, musicians, blondes, brunettes, SCUBA divers, computer operators, individuals, members, leaders, people, voters, Texans, friends or any other word

***People First Language recognizes that individuals with disabilities are — first and foremost — people. It emphasizes each person's value, individuality, dignity and capabilities. The following examples provide guidance on what terms to use and which ones are inappropriate when talking or writing about people with disabilities.***

| People First Language to Use | Instead of Labels that Stereotype & Devalue |
|---|---|
| ■ people/individuals with disabilities<br>an adult who has a disability<br>a child with a disability<br>a person | ■ the handicapped<br>the disabled |
| ■ people/individuals without disabilities<br>typical kids | ■ normal people/healthy individuals<br>atypical kids |
| ■ people with mental retardation<br>he/she has a cognitive impairment<br>a person who has Down syndrome | ■ the mentally retarded; retarded people<br>he/she is retarded; the retarded<br>he/she's a Downs kid; a Mongoloid; a Mongol |
| ■ a person who has autism | ■ the autistic |
| ■ people with a mental illness<br>a person who has an emotional disability<br>with a psychiatric illness/disability | ■ the mentally ill; the emotionally disturbed<br>is insane; crazy; demented; psycho<br>a maniac; lunatic |
| ■ a person who has a learning disability | ■ he/she is learning disabled |
| ■ a person who is deaf<br>he/she has a hearing impairment/loss<br>a man/woman who is hard of hearing | ■ the deaf |
| ■ person who is deaf and cannot speak<br>who has a speech disorder<br>uses a communication device<br>uses synthetic speech | ■ is deaf and dumb<br>mute |
| ■ a person who is blind<br>a person who has a visual impairment<br>man/woman who has low vision | ■ the blind |
| ■ a person who has epilepsy<br>people with a seizure disorder | ■ an epileptic<br>a victim of epilepsy |
| ■ a person who uses a wheelchair<br>people who have a mobility impairment<br>a person who walks with crutches | ■ a person who is wheelchair bound<br>a person who is confined to a wheelchair<br>a cripple |
| ■ a person who has quadriplegia<br>people with paraplegia | ■ a quadriplegic<br>the paraplegic |
| ■ he/she is of small or short stature | ■ a dwarf or midget |
| ■ he/she has a congenital disability | ■ he/she has a birth defect |
| ■ accessible buses, bathrooms, etc.<br>reserved parking for people with disabilities | ■ handicapped buses, bathrooms, hotel rooms, etc.<br>handicapped parking |

*Prepared by the Texas Council for Developmental Disabilities, 4900 N. Lamar Blvd., Austin, TX 78751-2399; 512-424-4092; 512-424-4099 TDD; 512-424-4097 fax; 1-800-262-0334; http://www.txddc.state.tx.us.*

use for a person.

# Describing People with Disabilities

What Do You Call People with Disabilities? Friends, neighbors, coworkers, dad, grandma, Joe's sister, my big brother, our cousin, Mrs. Schneider, George, a husband, wife, colleague, employee, boss, reporter, driver, dancer, mechanic, lawyer, judge, student, educator, home owner, renter, man, woman, adult, child, partner, participant, member, voter, citizen, amigo or any other word you would

## Who Are People with Disabilities?

People with disabilities are — first and foremost, people — people who have individual abilities, interests and needs. For the most part, they are ordinary individuals seeking to live ordinary lives. People with disabilities are moms, dads, sons, daughters, brothers, sisters, friends, neighbors, coworkers, students and teachers. About 49 million Americans — one out of every five individuals — have a disability. Their contributions enrich our communities and society as they live, work and share their lives.

## Changing Images Presented

Historically, people with disabilities have been regarded as individuals to be pitied, feared or ignored. They have been portrayed as helpless victims, repulsive adversaries, heroic individuals overcoming tragedy, and charity cases who must depend on others for their well being and care. Media coverage frequently focused on heartwarming features and inspirational stories that reinforced stereotypes, patronized and underestimated individuals' capabilities.

Much has changed lately. New laws, disability activism and expanded coverage of disability issues have altered public awareness and knowledge, eliminating the worst stereotypes and misrepresentations. Still, old attitudes, experiences and stereotypes die hard.

People with disabilities continue to seek accurate portrayals that present a respectful, positive view of individuals as active participants of society, in regular social, work and home environments. Additionally, people with disabilities are focusing attention on tough issues that affect quality of life, such as accessible transportation, housing, affordable health care, employment opportunities and discrimination.

## Eliminating Stereotypes — Words Matter!

Every individual regardless of sex, age, race or ability deserves to be treated with dignity and respect. As part of the effort to end discrimination and segregation — in employment, education and our communities at large — it's important to eliminate prejudicial language.

Like other minorities, the disability community has developed preferred terminology — People First Language. More than a fad or political correctness, People First Language is an objective way of acknowledging, communicating and reporting on disabilities. It eliminates generalizations, assumptions and stereotypes by focusing on the person rather than the disability.

As the term implies, People First Language refers to the individual first and the disability second. It's just the difference in saying the autistic and a child with autism. (See the other side.) While some people may not use preferred terminology, it's important you don't repeat negative terms that stereotype, devalue or discriminate, just as you'd avoid racial slurs and say women instead of gals.

Equally important, ask yourself if the disability is even relevant and needs to be mentioned when referring to individuals, in the same way racial identification is being eliminated from news stories when it is not significant.

*"The difference between the right word and the almost right word is the difference between lightning and the lightning bug." Mark Twain*

## What Should You Say?

Be sensitive when choosing the words you use. Here are a few guidelines on appropriate language.

- ❑ Recognize that people with disabilities are ordinary people with common goals for a home, a job and a family. Talk about people in ordinary terms.
- ❑ Never equate a person with a disability — such as referring to someone as retarded, an epileptic or quadriplegic. These labels are simply medical diagnosis. Use People First Language to tell what a person HAS, not what a person IS.
- ❑ Emphasize abilities not limitations. Say, for example, a man walks with crutches, not he is crippled.
- ❑ Avoid negative words that imply tragedy, such as afflicted with, suffers, victim, prisoner and unfortunate.
- ❑ Recognize that a disability is not a challenge to be overcome, and don't say people succeed in spite of a disability. Ordinary things and accomplishments do not become extraordinary because they are done by a person with a disability. What is extraordinary are the lengths people with disabilities have to go through and the barriers they have to overcome to do the most ordinary things.
- ❑ Use handicap to refer to a barrier created by people or the environment. Use disability to indicate a functional limitation that interferes with a person's mental, physical or sensory abilities, such as walking, talking, hearing and learning. For example, people with disabilities who use wheelchairs are handicapped by stairs.
- ❑ Do not refer to a person as bound to or confined to a wheelchair. Wheelchairs are liberating to people with disabilities because they provide mobility.
- ❑ Do not use special to mean segregated, such as separate schools or buses for people with disabilities, or to suggest a disability itself makes someone special.
- ❑ Avoid cute euphemisms such as physically challenged, inconvenienced and differently abled.
- ❑ Promote understanding, respect, dignity and positive outlooks.

# HOUSEHOLD SAFETY ORIENTATION

Be familiar with the following household safety reminders.

## Inside the House

- Know where emergency phone numbers are kept.
- Be familiar with emergency 911 procedures.
- Be aware of the person's fire evacuation plan, exits, and locations of fire extinguishers.
- Perform periodic fire drills. Document these in your communication log if asked to do so by your employer.
- Ensure outside doors are locked at all times. Do not open the door to an unfamiliar face. Ask for identification and call someone to verify who they are.
- Don't give information to individuals calling over the phone. Take a name and phone number to return calls.
- Make sure clutter is cleared from main living areas, especially from pathways. Prevent tripping hazards.
- Make sure hazardous items, cleaners, chemicals, medications, etc. are kept out of reach.
- Know how to use specialized medical equipment or where instructions are kept.
- In case of power outages during severe weather, know of a second location to move to if necessary; another family member, neighbor, community site, etc.

## Outside the House

- Keep steps and walkways free of objects.
- Light walkways and porches at night. Make sure these areas remain free of tripping hazards.
- Follow manufacturer instructions for outdoor recreation equipment (trampolines, swing sets, etc).

## Motor Vehicle Safety

- Do a visual check of the vehicle (look for proper tire inflation, all signal lights and covers should be intact, no loose parts, etc. apparent) before starting.
- Move all vehicles immediately OUT of the garage when warming before taking trips. THE OPERATOR MUST BE IN THE DRIVER'S SEAT AT ALL TIMES WHEN THE ENGINE IS RUNNING. Turn the vehicle OFF before loading.
- All occupants of a motor vehicle need to be wearing a seatbelt, be seated in an approved car seat or wheelchair seat restraint BEFORE leaving the driveway and shall remain in their restraints while the vehicle is in operation.

## Incident Reports

You are required to complete an incident report during your shift if any of the following events should occur. Discuss any situation or concern with your employer or the Support Coordinator so that appropriate follow-up can be made to minimize future problems.

- Actual and suspected incidents of abuse, neglect, exploitation, or maltreatment per the DHS/DSPD Code of Conduct and Utah Code
- Drug or alcohol abuse
- Medication overdoses or errors reasonably requiring medical intervention
- Missing person
- Evidence of seizure in a person with no seizure diagnosis
- Significant property destruction (Damage totaling $500.00 or more is considered significant)
- Physical injury reasonably requiring medical attention
- Law enforcement involvement
- Use of restraints or timeout rooms.
- Any other instances the person or representative determines should be reported.

You, the person or the employer MUST notify the Support Coordinator of any reportable incident that happens while the person is in the care of an employee within 24 hours. Initial notification may be in the form of a phone call, e-mail or fax.

An incident report form MUST be completed within 5 business days of the incident and sent to the Support Coordinator.

Refer to blank copy of this form in the Daily File

Utah DHS-DSPD
5/03

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES



FORM 1-8

# INCIDENT REPORT FORM

| | | |
|---|---|---|
| PERSON'S ID: 0___ ___ ___ ___ ___ ___ ___ ___ | PERSON'S NAME: | |
| TODAY'S DATE: ____/____/____ MM DD YY | DATE INCIDENT STARTED: ____/____/____ MM DD YY | TIME INCIDENT STARTED: _____ AM/PM |
| YOUR NAME: | DATE INCIDENT ENDED: ____/____/____ MM DD YY | TIME INCIDENT ENDED: _____ AM/PM |
| YOUR TITLE: | YOUR PHONE NUMBER: ( ) | |
| PROVIDER NAME: | PROVIDER SITE ADDRESS: | City: |
| NUMBER OF PEOPLE INVOLVED (INCLUDING PERSON IN SERVICES LISTED ABOVE): | | |
| **NAMES and ROLES OF OTHERS INVOLVED or WITH PERTINENT INFORMATION, INCLUDING HEALTH CARE PROVIDERS, IF ANY:** ***(DO NOT INCLUDE PERSON IN SERVICES LISTED ABOVE):*** | | |
| NAME: | ROLE: | |
| NAME: | ROLE: | |
| NAME: | ROLE: | |
| WHERE DID INCIDENT TAKE PLACE? | ☐ Provider Site Listed Above ☐ Day Program ☐ School ☐ Friend's Home ☐ Relative's Home ☐ Other Location (Describe Briefly): | |

**ACTION TAKEN?**

| | | |
|---|---|---|
| MEDICAL PROFESSIONAL NOTIFIED? | ☐ Yes ☐ No | Name: Title: Phone: |
| PERSON HOSPITALIZED? | ☐ Yes ☐ No | Hospital's Name: Phone: |
| POLICE NOTIFIED? | ☐ Yes ☐ No | Date: ____/____/_____ Time:_____ AM / PM |
| APS or CPS NOTIFIED? | ☐ Yes ☐ No | Date: ____/____/_____ Time: _____ AM / PM |

**TYPE OF INCIDENT?**

| | |
|---|---|
| ☐ **INJURY** | Who Was Injured? ☐ Person in Services ☐ Another/Other Person(s) in Services ☐ Staff ☐ Other:<br>Who caused the injury? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other:<br>Body part(s) injured:<br>Severity/Treatment: |
| ☐ **ABUSE** | Who was abused? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other:<br>Who caused the abuse? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other:<br>Type of Abuse/Exploitation: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Financial<br>Abuse was: ☐ Observed ☐ Suspected<br>Severity/Treatment: |
| ☐ **CRIMINAL ACT** | Type of Act: |
| ☐ **DRUG/ALCOHOL** | ☐ Incident ☐ Overdose<br>Drug/Alcohol involved:<br>Severity/Treatment: |
| ☐ **Med Error** *(Resulting in Medical Procedure)* | Medication(s) involved:<br>Severity/Treatment: |
| ☐ **Missing Person** | Date Last Seen: ____/____/_____ Time Last Seen:_____ AM / PM<br>Where last seen?<br>Date Found/Returned: ____/____/_____ Time Found/Returned:_____ AM / PM |
| ☐ **SEIZURE**[1] | Duration:<br>Brief Description of Event: |
| ☐ **RESTRAINT**[2] Authorized by:<br>Name:_____<br>Title:_____ | Cause: ☐ Aggression ☐ Self-Injurious Behavior (SIB) ☐ Other:<br>Number of Minutes Person was Restrained: |
| ☐ **Property Destruction**[2] | Item(s) Destroyed: Cost to repair/replace? $_____.____<br>Owner(s) of Item(s) destroyed: |
| ☐ **OTHER INCIDENT** | Please provide brief description: |

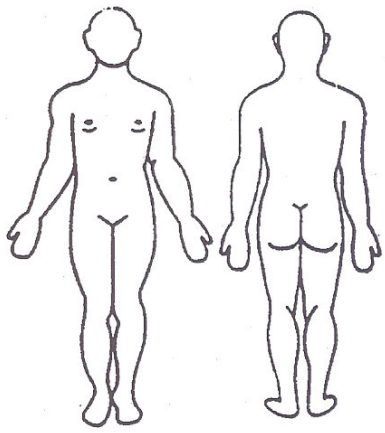
[1]If person has a diagnosis of Seizure Disorder, a monthly summary of seizures may be used instead of this form.
[2]If person destroys property or is restrained more than once a month, a monthly summary of incidents may be used instead of this form.

**INCIDENT REPORT FORM**

**FORM 1-8**

**Describe Incident in Detail;**
**Include How Each Person Was Involved:**

**Please mark the body parts injured**



| **Provider Signature:** | **Title:** |
|---|---|

**Support Coordinator Recommendation / Follow-Up:**
*(Attach APS or CPS Referral Sheet and Final Outcome of Investigation)*

| **Support Coordinator Signature:** | **Date Notified:** | **Today's Date:** |
|---|---|---|

# Human Rights

1. The right to be treated at all times with courtesy, respect and dignity;
2. The right to be treated equally as a citizen under the law, including the guarantees of privileges afforded under the Constitution of the United States;
3. The right to receive support in an appropriate, safe, sanitary environment that complies with local, state, and federal standards;
4. The right to nutritious food, and support for health and well-being
5. The right to practice the religion of choice or to abstain from such practice;
6. The right to timely access to appropriate medical and dental treatment including medication;
7. The right to access available supportive services including, occupational therapy, physical therapy, speech therapy, behavior modification and psychology services, and other necessary services as approved by the payer;
8. The right to receive appropriate supports in the most inclusive and least intrusive manner;
9. The right to personal privacy;
10. The right to communicate freely with others in any reasonable manner, including social interactions with members of either sex;
11. The right to pursue economic opportunities;
12. The right to be free from physical, emotional, psychological, or sexual abuse, neglect and exploitation;
13. The right to participate in all decisions affecting the person's life;
14. The right to present grievances;
15. The right to choose among available options;
16. The right to be free from inappropriate chemical or physical restraint;
17. The right to access personal money and possessions;
18. Any additional rights outlined in the contracting agency's policy;
19. The right to have records kept confidential;
20. The right to disagree with **Support Coordinator**s and provider staff and to choose who the **Support Coordinator** or **Provider** of services will be according to the options available in the area where the **Person** resides.

**Division of Services for People with Disabilities**

# Service Specific Training

**for DTP (Daily Transportation Payment)**
**Self-Administered Services**

If you provide transportation, you must abide by the following guidelines.

1. Persons are not to be left unattended in the vehicle.

2. Persons must remain seated while the vehicle is in motion.

3. Keys must be removed from the vehicle at all times when the driver is not in the driver's seat unless operating a lift on vehicles that require the keys to be in the ignition to operate the lift.

4. All persons in wheelchairs must use seat belts or locking mechanisms to immobilize wheelchairs during travel.

5. Persons must be transported in safety restraint seats when required by Utah State law.

6. Vehicles used for transporting persons must have working door locks. Doors are to be locked at all times while the vehicle is moving.

7. During an emergency, the employee is responsible for the person until relief or help arrives.

8. Failure to serve the person under these terms may be cause for termination of this service.

## Division of Services for People with Disabilities

# Service Specific Training
## (Direct Service Training)
## Self-Administered

**Date:**_____
**For:** _____ **Prepared by:**_____

**Important information to know when providing direct services.**

1. **Medication Taken**

| Medication Name | Purpose | Possible Side Effects |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

2. **Instructions for supporting medication:**

_____
_____
_____

3. **Physical needs** (list any illness, diagnosis, etc. the employee should be aware of when supporting the person)**:**

_____
_____
_____

4. **Dietary concerns or allergies** (note item and reaction)**:**

5. **Important health needs:**

6. **Special instructions for eating or swallowing:**

7. **Note age appropriate community activities and natural supports that are important to the person:** (Age appropriate refers to activities that are similar to what peers at the same age may enjoy.)

8. **Things the person likes:**

9. **Physical limitations and concerns or equipment needs: (Refer to** the How to Use Equipment form if needed.)

10. **Discuss how the person's preferred recreational and leisure activities can be developed:** (This may be included on the Support Strategy.)

# HOW TO COMPLETE AND SUBMIT A TIMESHEET

A timesheet entry needs to be completed each time you work indicating the **exact** time you begin and end your shift. Depending on the service you provide and the time spent, you will either enter a quarter hour, or a daily rate. You are required to make a brief comment on the timesheet of the service provided during your shift.

**Follow the Utah Timesheet Instructions Below:**

Provide **complete and correct** information on the timesheet or you will be asked make necessary corrections, which may delay your payment.

1. Enter your name (LAST NAME, FIRST NAME)
2. Enter your ID (Social Security Number)
3. Enter the person receiving services' name (LAST NAME, FIRST NAME)
4. Enter the person's ID number (DSPD 0-nine digit number)
5. Enter the service date – the date that you worked (Month/Day/Year)
6. Enter the time you began and ended work. Indicate a.m. or p.m. hours. (12:00 noon is p.m. and 12:00 midnight is a.m.)
7. Enter the corresponding service code using the following letter codes as applicable:
   - CO1 - Companion - quarter hour/daily
   - RP1 - Respite - quarter hour/daily
   - RP6 - Respite - daily
   - RP7 - Respite-Group - quarter hour/daily
   - RP8 - Respite-Group (room and board)- quarter hour/daily
   - TF1 - Family Training and Preparation - quarter hour
   - SL1 - Supported Living - quarter hour/daily

HS1 - Homemaker Supports - quarter hour
CH1 - Chore Services - quarter hour
PA1 - Personal Assistance - quarter hour/daily
DTP - Transportation /per mile

8. Enter a **Comment** of the service provided. This should be brief and related to the goal addressed in the Support Strategy.
9. Make sure that you and your employer sign.
10. Enter dates by the signatures

Your employer may contact the Fiscal Agent with any questions concerning filling out a timesheet.

**Time-Line for Payroll:**

- Your employer may fax or mail signed timesheets to the Fiscal Agent by the deadline of the 1st and 16th of each month.
- Timesheets received on or before the 1st of the month will be paid on the 15th.
- Timesheets received on or before the 16th of the month will be paid on the 30th.

Variations in the payroll schedule may occur due to holiday and weekend dates. Refer to the Payroll Schedule provided by the Fiscal Agent. This schedule may be included in the Daily File.

## Payroll may NOT be processed if it is received more than 30 days following the month services were provided

**Information Change:**

Inform your employer of any changes, such as address or name change so they can notify their Fiscal Agent on your behalf.

# WHO TO CONTACT FOR HELP

**Background Checks:** Contact the Division office at 801-538-4200

**Payments or Billing Problems**: Contact your employer or the Support Coordinator, they will contact the Fiscal Agent on your behalf

**Concerns or Problems:** Discuss with your employer or the Support Coordinator. You should ask for the name and phone number of the person's Support Coordinator.
Name: _____
Phone number: _____

Notes:
_____
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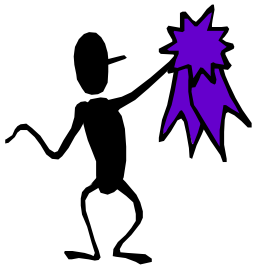

# Congratulations!!!

You have completed required employee training for Self-Administered Services

## WELCOME TO THE TEAM!

# EMPLOYEE ANNUAL REQUIREMENTS

This section will help you understand annual requirements. You may choose to review these items at the same time as the person's annual meeting.

## This Section Includes:

- Employee Annual Requirements

# EMPLOYEE ANNUAL REQUIREMENTS

The annual meeting allows the person and their team to review services and select new goals. The team consists of the person, the employer, you, the Support Coordinator and others who can help in planning supports.

## Complete the Following:

- Confirm that you have updated or complete an annual Background Screening Application (BSA). Include a copy of a Utah driver's license or state picture ID with the application. Send both items to:

**Division of Services for People with Disabilities**
**Att: BSA**
**120 N. 200 W. #411**
**Salt Lake City, Utah 84103**

**Information to Remember when Completing the Background Screening (BCA) Application:**

- Enter the client ID# (This number is located in the Daily File. It begins with a 0.)
- Complete all sections of the BSA (both sides).
- Enter complete full name. If there is no middle name enter N/A.
- Submit with a clear copy of a current Utah Driver's License or other State ID issued by the Division of Motor Vehicles.
- READ the instructions.
- Renewals will be sent to your residence on an annual basis and need to be completed within 30 days.

- Provide your employer with any changes to your status, such as a change in address or name.
- Review updates to the person's Support Strategies.
- Give input to the person's annual meeting noting successes, and current needs. Attend if you are able as part of the team.
- Review current Service Specific training updates made by your employer.
- Know if the service you have been providing is the same or if changes have been made to better meet the person's needs.
- Review timesheet and comment requirements. Be familiar with possible updates.
- Review Employee Training and Orientation as needed.

# DISABILITY RESOURCE BOOK

***Compiled by the Utah Parent Center***

**January 2007**

***This book can be downloaded by visiting: www.utahparentcenter.org***

***PLEASE SEND UPDATES TO THIS BOOK TO KATIE ROWLEY AT THE UTAH PARENT CENTER; KATIER@UTAHPARENTCENTER.ORG.***

## 2-1-1 UTAH INFORMATION AND REFERRAL CENTER

**Address:** 1025 South 700 West
Salt Lake City, UT 84104
**Phone:** 211
**Toll-free:** (888) 826-9790
**Website:** www.informationandreferral.org
**Purpose:** 211 Info Bank, a program of Community Services Council, is a free information and referral line for health, human, and community services. 211 provides information and referral on topics such as emergency food pantries, rental assistance, public health clinics, childcare resources, support groups, legal aid, and a variety of non-profit, governmental agencies.

## ACCESS UTAH NETWORK

**Address:** 155 South 300 West, Suite 100
Salt Lake City, UT 84101
**Phone:** (801) 533-4636
**Toll-free:** (800) 333-8824
**Website:** www.accessut.org
**Purpose:** Access Utah Network is a statewide information and referral service providing information on issues related to people with disabilities. Information is disseminated primarily via telephone. On their website, you can find information on disability-related events, services, and products.

## ACCESSIBLE HOMES FOUNDATION (AHF)

**Address:** P.O. Box 26383
Salt Lake City, UT 841126-0383
**Phone:** (801) 969-8475
**Website:** www.acceshomes.org
**Purpose:** The AHF is dedicated to promoting the development of accessible homes for people with disabilities, educating home builders and the public on the need for accessible housing, specifying criteria for accessible homes, listing accessible homes for sale or rent, providing referrals to other agencies as needed, and planning to assist low income persons with disabilities to have a home to meet their needs.

## ACUMEN

**Address:** 240 West Center, Suite 100
Orem, UT 84059
**Toll-free:** (888) 221-7014
**Website:** www.acumenfiscalagent.com
**Purpose:** Acumen was founded in 1995 on the simple premise: There has to be a better, simpler, more efficient way to provide accounting and technical services in the social service environment. Acumen offers complete accounting services for companies engaged in social services. They also provide services specific to payroll, financial planning, company setup, and business development.

## AGING AND ADULT SERVICES, DIVISION OF

**Address:** 120 North 200 West, Room 325
Salt Lake City, UT 84103
**Phone:** (801) 538-3910
**Toll-free:** (877) 424-4640
**Website:** www.hsdaas.state.ut.us
**Purpose:** The Division administers the Adult Protective Services program to protect seniors and disabled adults from abuse, neglect, or exploitation. Adult Protective Services workers provide services designed to assist victims.

## ALEXANDER GRAHAM BELL ASSOCIATION FOR THE DEAF AND HARD OF HEARING - UTAH CHAPTER

**Address:** 521 East 500 North
Orem, UT 84097
**Phone:** (801) 765-1096
**Website:** www.agbell-utah.org
**Purpose:** The AG Bell Association for the Deaf and Hard of Hearing is the world's oldest and largest membership organization promoting the use of spoken language by children and adults with hearing loss. Members include parents of children with hearing loss, adults who are deaf or hard of hearing, and professionals in fields related to hearing loss and deafness. Through advocacy, publications, financial aid, and scholarships, and numerous programs and services, AB Bell promotes its mission: Advocating independence through Listening and Talking!

## ALLIES WITH FAMILIES

**Address:** 124 South 400 East, #250
Salt Lake City, UT 84111
**Phone:** (801) 433-2595
**Fax:** (801) 521-0872
**Website:** www.allieswithfamilies.org
**Purpose:** Allies with Families, the Utah Chapter of the Federation of Families for Children's Mental Health was created in 1991 to offer practical support and resources for parents and their children and youth who face serious emotional, behavioral, and mental health challenges.

## THE ARC OF UTAH

**Address:** 155 South 300 West, Suite 201
Salt Lake City, UT 84101
**Phone:** (801) 364-5060
**Toll-free:** (800) 371-5060
**Website:** www.arcutah.org
**Purpose:** The Arc of Utah is a nonprofit; grassroots organization founded over 40 years ago by a small group of parents and others concerned about the rights of people with developmental disabilities (DD).

## ASSIST, INC.

**Address:** 218 East 500 South
Salt Lake City, UT 84111
**Phone:** (801) 355-7085
**Purpose:** Accessibility design for home modifications.

## AT HOME AMERICA

**Phone:** (801) 699-2903
**Website:** www.athome.com/yourpeddlertracie
**Purpose:** AtHome America is on a mission to change America, one heart, one home, one family at a time. Their goal is to be a positive influence in the life of every person we touch through AtHome America. They encourage families to enjoy *Real life with style*, by enhancing their lives - spiritually, personally and professionally.

## AUTISM INFORMATION RESOURCES AT THE UTAH PARENT CENTER (FORMERLY AUTISM SOCIETY OF UTAH)

**Address:** 2290 East 4500 South, Suite 110
Salt Lake City, UT 84117-4428
**Phone:** (801) 272-1051
**Toll-free:** (800) 468-1160
**Website:** www.utahparentcenter.org
**Purpose:** The Autism Information Resources at the Utah Parent Center provides information, referral and trainings to families and professionals who live and work with individuals with autism and autism spectrum disorders, such as Aspergers.

## BABY WATCH EARLY INTERVENTION - UTAH DEPARTMENT OF HEALTH

**Address:** 44 North Medical Drive
P.O. Box 144720
Salt Lake City, UT 84114-4720
**Phone:** (801) 584-8201
**Toll-free:** (800) 961-4226
**Website:** www.utahbabywatch.org
**Purpose:** This program provides early identification and develpmental services for families of infants and toddlers, birth to age three. There are 16 local programs in the state of Utah that provide these Early Intervention services. A list of service providers and locations can be downloaded by visiting their website.

## BIG MAK'S (MOMS OF AUTISTIC KIDS)

**Phone:** (801) 944-1729
**Purpose:** MAK's is dedicated to giving and offering support to other mothers of children with Autism Spectrum Disorders. They have a support group and a play group that meet regularly. They also have a lot of fun stuff to buy!

## BLIND AND VISUALLY IMPAIRED, DIVISION OF SERVICES FOR THE

**Address:** 250 North 1950 West, Suite B
Salt Lake City, UT 84116-7902
**Phone:** (801) 323-4343
**Purpose:** The DSBVI has developed programs to help meet the needs of Utah citizens who are blind or have significant visual impairments. In addition to providing vocational rehabilitation services, DSBVI offers other services including. These services are provided to individuals at the Center for the Blind and in the community statewide.

## BRAIN INJURY ASSOCIATION OF UTAH, INC.

**Address:** 1800 South West Temple, Suite 203
Salt Lake City, UT 84115
**Phone:** (801) 484-2240
**Toll-free:** (800) 281-8442
**Website:** www.biau.org
**Purpose:** This Association is the only non-profit organization dedicated exclusively to education and support for the issues of prevention and recovery of brain injury in the state of Utah.

## CARMEN B. PINGREE SCHOOL FOR CHILDREN WITH AUTISM (PRIVATE SCHOOL)

**Address:** 780 S. Guardsman Way
Salt Lake City, UT 84108
**Phone:** (801) 581-0194
**Website:** www.carmenbpingree.com
**Purpose:** The mission of the Carmen B. Pingree School for Children with Autism is to provide comprehensive treatment, education, and related services for children with autism and their families. They use and develop best practices, validated by research, while treating students and their families with dignity and respect. They partner with families, universities, service agencies, the government and our community to assist and lift those affected by autism, its causes and eventual cure.

## C.A.S.T. FOR KIDS

**Phone:** (801) 524-3664
**Website:** www.castforkids.org
**Purpose:** C.A.S.T. for kids was formed in 1991 to join volunteers who love to fish with disabled and disadvantaged children for a day of fishing in the outdoors. People can leave their problems on the shore for a day of fun on the water!

## CENTER FOR PERSONS WITH DISABILITIES, UTAH STATE UNIVERSITY

**Address:** 6880 Old Main Hill
Logan, UT 84332
**Phone:** (435) 797-8137
**Toll-free:** (866) 284-2821
**Website:** www.cpd.usu.edu
**Purpose:** It is their vision that individuals and their family members exercise independence and self-determination across their lifespan as communities support full participation and informed choices. They also focus on education and awareness of Americans with Disabilities Act (ADA), targeting businesses, community organizations, and individuals.

## CENTRAL UTAH CENTER FOR INDEPENDENT LIVING

**Address:** 491 North Freedom Blvd.
Provo, UT 84601
**Phone:** (801) 466-5565 (Voice)
(801) 466-9910 (TTY)
**Website:** www.cucil.org
**Purpose:** To assist persons with disabilities in achieving greater independence by providing services and activities which enhance independent living skills and promote the public understanding, accommodation and acceptance of their rights, needs and abilities.

## CHADD OF UTAH

**Recorded Information:** (801) 537-7878
**Website:** www.chaddofutah.com
**Purpose:** CHADD is an all-volunteer organization dedicated to be your source on AD/HD issues! (CHADD = Children and Adults with Attention Deficit/Hyperactivity Disorder)

## CHILD AND FAMILY SERVICES, DIVISION OF

**Address:** State Department of Human Services
120 North 200 West, #225
Salt Lake City, UT 84103
**Phone:** (801) 538-4100
**Purpose:** Provide social services to people who meet eligibility requirements; responsible for programs for families, adults, and children.

## CHILD CARE RESOURCE AND REFERRAL METRO

**Phone:** (801) 355-HUGS
**Toll-free:** (866) 438-4847
**Website:** www.cssutah.org/childcare
**Purpose:** To connect families to child care. Serves Salt Lake and Tooele Counties and can connect you to Child Care Resource and Referral throughout Utah.

## CHILDREN WITH SPECIAL HEALTH CARE NEEDS, BUREAU OF

**Address:** Utah Department of Health
Division of Community and Family Health Services
44 North Medical Drive
**Mailing Address:**
P.O. Box 144610
Salt Lake City, UT 84114-4610
**Phone:** (801) 584-8284
**Toll-free:** (800) 829-8200
**Website:** http://health.utah.gov/cshcn
**Purpose:** To improve the health and functional status of all children in Utah with Special Health Care needs by assuring access to comprehensive, coordinated, and quality care that is family-centered and community-based.

## COMMON GROUND OUTDOOR ADVENTURES

**Address:** 355 North 100 East
Logan, UT 84321
**Phone:** (435) 713-0288
**Website:** www.cgadventures.org
**Purpose:** Common Ground Outdoor Adventures' mission is to provide affordable and accessible recreational opportunities for youth and adults with disabilties in Northern Utah.

## COMMUNITY AND FAMILY HEALTH SERVICES, DIVISION OF

**Mailing Address:**
Box 142001
Salt Lake City, UT 84114-2001
**Phone:** (801) 538-6161
**Purpose:** CFHS provides services that are related to health promotion, maternal and child health, and services for children with special health care needs. Priority activities for the CFHS Division include: Improve the coordination of health services by using better information systems; Reduce Utah's high rate of suicide among young men; Improve Utah's immunization rates; Reduce smoking and help teens and adults quit; Improve access to preventive dental care as well as dental treatment services; Provide more coordination for early childhood services to families; Address the epidemic of overweight and obese Utahans; and Screen all children for special health care needs.

## COMPUTER CENTER FOR CITIZENS WITH DISABILITIES

**Address:** 1595 West 500 South
Salt Lake City, UT 84104
**Phone:** (801) 887-9380
**Toll-free:** (888) 866-5550
**Purpose:** To help improve the lives of children and adults with disabilities by introducing them to the ways in which microcomputer technology can enhance their jobs, careers, and education.

## COURAGE REINS – THERAPEUTIC RIDING CENTER

**Address:** 5870 West 10400 North
Highland, UT 84003
**Phone:** (801) 756-8900
**Website:** www.couragereins.org
**Purpose:** The Mission of Courage Reins is to improve the quality of life for people with disabilities. Through therapeutic horseback riding and other equine based activities, we provide a safe, fun, and challenging setting for physical, cognitive, social, and emotional growth.

## CTA - COMMUNITY SUPPORTS

**Address:** 4444 South 7000 East, #203
Salt Lake City, UT 84107
**Phone:** (801) 268-4887
**Toll-free:** (888) 268-4887
**Purpose:** CTA is a private non-profit organization that provides support for people with autism and their families and helps promote community acceptance. They provide residential support, day support, and family support.

## DDI VANTAGE EARLY INTERVENTION PROGRAM

**Address:** 535 East 4500 South #D 240
Salt Lake City, UT 84107
**Phone:** (801) 266-3939, ext 0 for Operator
**Website:** www.ddivantage.com
**Purpose:** DDI Vantage Early Intervention Program serves children under the age of 3 who have developmental delays and disabilities.

## DEAF AND HARD OF HEARING, DIVISION OF SERVICES FOR THE

**Address:** 5709 South 1500 West
Salt Lake City, UT 84123
**Phone:** (801) 263-4861 (Voice)
**Phone:** (801) 263-4860 (TTY)
**Toll-free:** (800) 860-4860 (Voice and TTY)
**Website:** www.deafservices.utah.gov
**Purpose:** An organization through which the general welfare of the deaf and hard of hearing can be improved.

## DENTAL HOUSE CALL PROGRAM

**Address:** 2570 West 1700 South, #142
Salt Lake City, UT 84104
**Phone:** (801) 977-0309
**Toll-free:** (800) 427-0338
**Purpose:** Provide comprehensive dental treatment in the homes of those unable to leave their residence to visit a dental office. Program serves only homebound or institutionalized persons.

## DISABILITY LAW CENTER

**Address:** 205 North 400 West
Salt Lake City, UT 84103
**Phone:** (801) 363-1347
**Toll-free:** (800) 662-9080
**Website:** www.disabilitylawcenter.org
**Purpose:** The Disability Law Center is a private, non-profit organization designated by the Governor to protect the human and civil rights of people with disabilities in Utah through legal advocacy. Their services are statewide and free of charge.

## DISABILITY RIGHTS ACTION COMMITTEE

**Address:** 3565 South West Temple, #16
Salt Lake City, UT 84115
**Phone:** (801) 685-8214
**Purpose:** A non-profit organization committed to expanding and assuring the rights of people with disabilities so they can "boldly go where everyone else has gone before".

## DISABILITY SUPPORT CENTER FOR FAMILIES

**Address:** 1574 West 1700 South
Salt Lake City, UT 84104
**Phone:** (801) 973-0206
**Email:** disabilitysupport@cpd2.usu.edu
**Purpose:** The Disability Support Center for Families will help you design a plan for your future and find resources including healthcare, medical equipment, respite, food stamps, cash assistance, heating, and more. They can also help you find education, training, and work. Their services are free of charge. If you have a disability or a family member has a disability, go see them or call them – they can come to your home!

## DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES, (DSPD) ADMINISTRATION

**Address:** 120 North 200 West Room 411
Salt Lake City, UT 84103
**Phone:** (801) 538-4200 (Voice) or (801) 538-4192 (TTY)
**Toll-free:** (800) 837-6811
**Website:** www.hsdspd.utah.gov
**Purpose:** They promote opportunities and provide support for persons with disabilities to lead self-determined lives. They oversee home and community-based services for more than 4,000 people who have disabilities. Support includes: community living, day services, supported employment services, and support for people with disabilities and their families.

| | | | |
|---|---|---|---|
| **American Fork Office**<br>861 E. 900 North<br>American Fork, UT 84003<br>(801) 763-4100 | **Blanding Office**<br>522 North 100 East<br>Blanding, UT 84511<br>(435) 678-1440 | **Brigham City Office**<br>1050 South 500 West<br>Brigham City, UT 84302<br>(435) 734-4075 | **Cedar City Office**<br>106 North 100 East<br>Cedar City, UT 84720<br>(435) 865-5650 |
| **Clearfield Office**<br>1350 East 1450 South<br>Clearfield, UT 84015<br>(801) 776-7300 | **Delta Office**<br>39 South 300 East<br>PO Box 1038<br>Delta, UT 84624<br>(435) 864-3869 | **Heber Office**<br>69 North 600 West<br>Heber City, UT 84032<br>(435) 657-4206 | **Logan Office**<br>115 Golf Course Rd., Suite C<br>Logan, UT 84321<br>(435) 787-3450 |
| **Manti Office**<br>50 South Main St., Suite 5<br>Manti, UT 84642<br>(435) 835-0795 | **Moab Office**<br>1165 S Highway 191<br>Moab, UT 84532<br>(435) 259-3728 | **Nephi Office**<br>54 North Main St.<br>PO Box 45<br>Nephi, UT 84648<br>(435) 623-2431 | **Ogden Office**<br>2540 Washington Blvd.<br>3rd Floor<br>Ogden, UT 84402<br>(801) 626-3300 |
| **Park City Office**<br>1764 Prospector Square<br>Park City, UT 84060<br>(435) 645-8703 | **Price Office**<br>475 W Price River Dr. #262<br>Price, UT 84501<br>(435) 636-2390 | **Provo Office**<br>150 E. Center St.<br>Provo, UT 84606<br>(801) 374-7005 | **Richfield Office**<br>201 East 500 North<br>Richfield, UT 84701<br>(435) 896-1281 |
| **Salt Lake City Office**<br>655 East 4500 South, Suite 200<br>Salt Lake City, UT 84107<br>(801) 264-7620 | **Spanish Fork Office**<br>607 East Kirby Lane<br>Spanish Fork, UT 84660<br>(801) 794-6700 | **St. George Office**<br>377 E. Riverside Dr.<br>Bldg B; Suite A<br>St. George, UT 84790<br>(435) 674-3961 | **Tooele Office**<br>305 North Main St.<br>Tooele, UT 84074.<br>(435)833-7355 |
| **Vernal Office**<br>980 W. Market Dr.<br>Vernal, UT 84078<br>(435) 789-9336 | **Utah State Developmental Ctr.**<br>895 North 900 East<br>American Fork, UT 84003<br>(801) 763-4090 | **For more information and current contacts, visit: http://www.dspd.utah.gov/locationsmap.htm** | |

## DOWN SYNDROME, SEE UTAH DOWN SYNDROME FOUNDATION

## EARLY INTERVENTION SERVICES – *SEE BABY WATCH EARLY INTERVENTION PROVIDERS*

## EDWARD G. CALLISTER FOUNDATION

**Address:** P.O. Box 540041
North Salt Lake, UT 84054
**Phone:** (801) 366-HOPE
**Toll-free:** (800) 633-HOPE
**Website:** www.hopetoday.com
**Purpose:** The Edward G. Callister Foundation is dedicated to increasing public awareness of conditions that may make children and adults susceptible to substance abuse. The Foundation is committed to supporting research and education that furthers understanding of the diseases of addiction and to providing assessment, referrals, and clinical services that directly help those whose lives are affected.

## ENABLE INDUSTRIES, INC.

**Address:** 2640 Industrial Drive
Ogden, UT 84401
**Phone:** (801) 621-6595
**Toll-free:** (800) 378-6595
**Website:** www.enableindustries.com
**Purpose:** Enable Industries Inc. is a private, not-for-profit organization that has been providing jobs, skill training, and employment services to people with disabilities since 1968. With 57,000 square feet of production space and a workforce of over 245, Enable provides a variety of products and services to industry as a vehicle for jobs and job training for persons with disabilities.

## EPILEPSY ASSOCIATION OF UTAH

**Address:** 1995 West 9000 South, Level B
West Jordan, UT 84088
**Phone:** (801) 566-5949
**Website:** www.epilespyut.org
**Purpose:** The Epilepsy Association of Utah is dedicated to providing education and support services for individuals and families dealing with the many challenges of epilepsy.

## FAMILY RESOURCE LIBRARY – *CENTER FOR PERSONS WITH DISABILITIES, UTAH STATE UNIVERSITY*

**Address:** 6820 Old Main Hill
Logan, UT 84322-6820
**Phone:** (435) 797-0348
**Website:** www.cpd.usu.edu/familyresourcelibrary
**Purpose:** This library features a collection of videos and print materials containing information for families of persons with disabilities; also some software, etc. is available to try.

## FAMILY SUPPORT CENTER

**Midvale Center**
**Address:** 777 West Center Street
Midvale, UT 84047
**Phone:** (801) 255-6881
**Sugarhouse Center**
**Address:** 2020 South Lake Street
Salt Lake City, UT 84105
**Phone:** (801) 487-7778
**Purpose:** Created in 1977 to meet the needs of families in Salt Lake, services have expanded to include prevention outreach to schools, daycare centers, churches and civic organizations. Extensive efforts in reaching out to Salt Lake County's ethnically diverse communities have brought success, most notably through collaboration such as Midvale Community Building Community Initiative. Services and materials are available in Spanish.

## FAMILY-TO-FAMILY NETWORK
### *A PROGRAM OF DHS/DSPD*

**Address:** c/o Utah Parent Center
2290 East 4500 South, Suite 110
Salt Lake City, UT 84117-4428
**Phone:** (801) 272-1051
**Toll-free:** (800) 468-1160
**Purpose:** The Family-to-Family Network (formerly called Family Councils) is a statewide organization that provides education and support to families who have a member with a disability. There is a network of local support groups who support and meet regularly and locally. Call Aimee at the above numbers to find a group in your area.

## FETAL ALCOHOL COALITION, UTAH

**Phone:** (801) 476-0481 (Chris Stuart)
**Email:** pats@weberhs.org
**Website:** www.dsamh.utah.gov
**Purpose:** Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include: physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The Coalition is dedication to education and prevention of FAS.

## FIVE P MINUS SOCIETY (5P-)

**Phone:** (801) 392-2628
**Purpose:** The Family Support Group for Children with Cri du Chat Syndrome.

## GUARDIANSHIP ASSOCIATES OF UTAH, INC.

**Address:** 320 West 200 South, Suite 140-B
Salt Lake City, UT 84104
**Phone:** (801) 533-0203
**Purpose:** Guardianship Associates serves individuals who have mental retardation or related disabilities. They are dedicated to providing guardianship services and information.

## HEALTH DEPARTMENT, SALT LAKE CITY-COUNTY

**Address:** 2001 South State Street, S-2500
Salt Lake City, UT 84190-2150
**Phone:** (801) 468-2700
**Purpose:** The Health Department provides services that promote the achievement and maintenance of optimal health for all people in the community.

## HEALTH INFORMATION, EDUCATION AND SUPPORT – *SEE UTAH FAMILY VOICES*

## HEALTH SERVICES, JORDAN SCHOOL DISTRICT

**Address:** 7501 South 100 East
Midvale, UT 84047
**Phone:** (801) 412-2522
**Purpose:** Health Services is dedicated to increasing district awareness of the need for health insurance for all students and promoting and facilitating applications for Medicaid and state health insurance programs for children and adults in Jordan School District.

## HOME CHOICE

**Address:** 95 W. Golf Course Rd., Suite 104
Logan, UT 84332
**Phone:** (435) 753-1112
**Purpose:** HomeChoice is a single-family mortgage loan designed to meet the mortgage underwriting needs of people who have disabilities or have family members with disabilities living with them. HomeChoice mortgages offer flexibility in the areas of loan-to-value ratios, down payment sources, qualifying ratios, and the establishment of credit.

## INFORMATION AND REFERRAL CENTER

**Address:** 1025 South 700 West
Salt Lake City, UT 84104
**Phone:** (801) 978-3333
**Website:** www.informationandreferral.org
**Purpose:** Comprehensive resource center for information and referral in the area of human services.

## INDEPENDENT LIVING – DOLLE ENTERPRISE

**Contact:** Nancy Dolle
**Address:** 3895 West Owensboro Drive
West Jordan, UT 84084
**Phone:** (801) 955-5089

## INTERMOUNTAIN COLLABORATIVE TRANSITION CENTER

**Address:** Virginia Street at Fairfax Road
Salt Lake City, UT 84103
**Phone:** (801) 536-3523
(801)536-3567
**Purpose:** The ICTC is a nonprofit organization that contracts with other agencies and/or individuals to provide transition services for young adults with disabilities age 13 and older. Their mission is to help young adults move into adult health care, access adult services, create opportunities for adult living, and provide resources and education important for independence.

## JORDAN FAMILY EDUCATION CENTER

**Address:** 8449 South 150 West
Midvale, UT 84047
**Phone:** (801) 565-7442
**Website:** www.jordandistrict.org/depts/familyeducationcenter.html
**Purpose:** The Jordan Family Education Center, located at Copperview Elementary School, provides support services and classes for families and students in Jordan School District. These services are provided by the District's school psychologists, social workers and counselors. The center offers classes and short-term counseling on Tuesday, Wednesday and Thursday evenings. There are three quarters packed full of interesting classes and support groups covering a variety of topics like parenting skills, dealing with adolescence, attention deficit, anger, grief, single parenting, blended families and many more. These services are available to families at no cost as a service of the District.

## JORDAN VALLEY SCHOOL - *A program of Jordan School District*

**Address:** 7501 South 1000 East
Midvale, UT 84047
**Phone:** (801) 565-7588
**Purpose:** A school for the education of children with disabilities ages two through twenty-two.

## JUST FOR KIDS

**Contact:** Susan Horn, OTR/L
**Phone:** (801) 231-9207
**Purpose:** Occupational and speech therapy.

## KOSTOPULOS DREAM FOUNDATION/CAMP K

**Address:** 2500 Emigration Canyon Road
Salt Lake City, UT 84108
**Phone:** (801) 582-0700
**Website:** www.campk.org
**Purpose:** The Kostopulos Dream Foundation provides recreation and leisure opportunites year-round through two main programs, Camp Kostopulos Summer Camp and Community Based Leisure Education program. The community based program runs September through May and applies to kids, teens and adults. Participants participate in community activities such as: bowling, swimming, dining out, tours, the arts, and social events.

## KIDS ON THE MOVE – EARLY EDUCATION, INTERVENTION AND HEAD START SERVICES

**Address:** 475 West 260 North
Orem, UT 84057
**Phone:** (801) 221-9930
**Website:** www.kotm.org
**Purpose:** Kids On The Move is a non-profit organization based in Orem that provides support and services to children and families in Utah County. Kids On The Move serves families with children birth to age three, including families of children with special needs and also low-income families. Kids On The Move provides services and support to children and families through four main programs: Early Intervention, Early Head Start, the Early Education Center, and Resource Library.

## KIDS WORLD PRESCHOOL

**Address:** 1328 West Stern Drive
Taylorsville, UT 84123
**Phone:** (801) 243-3361
**Website:** www.kidsworldpreschool.org
**Purpose:** This unique preschool takes the traditional classroom and customizes learning for every child. Kids World staff works with children of all abilities such as: Autism, PDD, Speech Delays, Down Syndrome, Aspergers, Behavior challenges, Cerebral Palsy, and Developmental Delays. This specialized preschool also has many families enrolling their typical children in the classroom as peer models. Early childhood experts say that educating children with disabilities and without disabilities in the same classroom is highly beneficial. Early childhood educators also agree early intervention is a key to a child's success in education. This preschool highly specializes in Communication strategies and Autism Spectrum Disorders. Kids World Preschool also provides services for children who have or are at increased risk for physical, developmental, and behavioral, disorders.

## KINDRED SPIRITS

**Phone:** (801) 232-1430
**Website:** www.kindredspiritsart.org
**Purpose:** Kindred Spirits is a community based non-profit inclusive fine arts program desinged especially for children with diverse disabilities, their families and their friends. Children without disabilities work side by side thoswe with special needs and each is accompanied by an adult apprentice. Together everyone learns about art and each other.

## LEARNING DISABILITIES ASSOCIATION OF UTAH (LDAU)

**Address:** PO Box 900726
Sandy, UT 84090-0726
**Phone:** (801) 553-9156
**Website:** www.ldautah.org
**Purpose:** The Learning Disabilities Association of Utah (LDAU) is committed to a world where people with learning disabilities are valued and respected, and their potential realized. LDAU is committed to providing meaningful support that brings effective improvement to the lives of all people impacted by learning disabilities. Call or visit the website for information on membership, monthly meetings, and the annual LD conference.

## LEGISLATIVE COALITION FOR PEOPLE WITH DISABILITIES (LCPD)

**Address:** PO Box 120
Springville, UT 84663-0120
**Website:** www.lcpdutah.org
**Purpose:** The mission of LCPD is to advocate for public policy affecting all people in the state of Utah who have disabilities.

## LIAISON FOR INDIVIDUALS NEEDING COORDINATED SERVICES (L.I.N.C.S.)

**Address:** 5180 South Commerce Drive, Suite P
Murray, UT 84107
**Phone:** (801) 281-4425
**Toll-free:** (877) 335-4627
**Purpose:** L.I.N.C.S. assists individuals with disabilities, their families, community partners, and pertinent agencies in collaborating as a team to identify, design, and implement services and programs unique to the individual client.

## MEDICAL HOME PROJECT – *SEE UTAH MEDICAL HOME INTEGRATED SERVICES PROJECT*

## MENTAL HEALTH, DIVISION OF

**Address:** 120 North 200 West, Room 209
Salt Lake City, UT 84103
**Phone:** (801) 538-3939
**Purpose:** The Utah Division of Substance Abuse and Mental Health is the State agency responsible for ensuring that prevention and treatment services for substance abuse and mental health are available statewide. If you, a friend, or family member is struggling with a mental health problem or a problem with alcohol, tobacco or other drugs there is help available. Hope and recovery are possible.

## METDESK – DIVISION OF ESTATE PLANNING FOR SPECIAL KIDS

**Contact:** Gary Napel
**Address:** 9350 South 150 East, #150
Sandy, UT 84070
**Phone:** (801) 999-3708
**Website:** www.gnapel.metlife.com
**Purpose:** Planning isn't impossible! You just need to sit down with a professional and do it! Contact MetDESK to get information about how you can start planning for your future and the future of your child.

## MIRACLE LEAGUE ASSOCIATION OF UTAH

**Contact:** Carol Synder or Matt Udy
**Phone:** (435) 615-1932
**Phone:** (866) 542-6576
**Purpose:** The Miracle League removes the barriers which keep mentally and physically disabled children off the baseball field and lets the experience the joy of America's favorite pasttime. The Miracle League Association serves children between the ages of 3 and 19 who suffer from any physical or mental disabilities, which causes them to be excluded – whether intentional or not – from conventional youth baseball leagues.

## NATIONAL ABILITY CENTER

**Address:** P.O. Box 682799
3351 East Highway 248
Park City, UT 84098
**Phone:** (435) 649-3991
**Website:** www.nac1985.org
**Purpose:** The National Ability Center is committed to the development of lifetime skills for people of all ages and abilities by providing affordable outdoor sports and recreational experiences in a nurturing environment. The National Ability Center offers year round outdoor sports and recreation for people with disabilities and their families. The objective of these experiences is to build self-esteem, confidence, and physical development, thereby enhancing active participation in all aspects of community life. Currently, the Center offers a full range of session lessons, trips, camps and retreats. The Ability Center is home to the Park City Disabled Ski Team and the first adaptive bobsled team in the nation. Located on a 26-acre ranch in Park City, Utah, the Center can provide overnight accommodations in their onsite bunk house.

## NATIONAL ASSOCIATION FOR CHILD DEVELOPMENT (NACD)

**Address:** 549 25th St.
Ogden, UT 84401
**Phone:** (801) 621-8606
**Website:** www.nacd.org
**Purpose:** NACD provides neurodevelopmental evaluations and individualized programs for children and adults, updated on a quarterly basis. As a family-centered organization, NACD stresses parent training and parent implementation of the program. NACD is an eclectic organization, gathering and utilizing the newest strategies that yield success and incorporating them into programs custom-designed for each client. Support is provided to families through video reviews, e-mail and telephone sessions.

## NAMI – UTAH *(NATIONAL ALLIANCE FOR THE MENTALLY ILL)*

**Address:** 450 South 900 East, Suite 160
Salt Lake City, UT 84102
**Phone:** (801) 323-9900
**Toll-free:** (877) 230-6264
**Website:** www.namiut.org
**Purpose:** NAMI is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, and other severe and persistent mental illnesses that affect the brain.

## NATIONAL MULTIPLE SCLEROSIS SOCIETY, UTAH CHAPTER

**Address:** 2995 S. West Temple, Suite C
Salt Lake City, UT 84115
**Phone:** (801) 493-0113
**Toll-free:** (800) 527-8116
**Website:** www.fightmsutah.org
**Purpose:** The Utah State Chapter strives to achieve its mission by helping people with MS in the following areas: emotional health, physical health, knowledge of MS, family and social support, independent living, long-term care, employment, and accessibility.

## NOW I CAN – CENTER FOR INTENSIVE THERAPY

**Address:** 560 South State Street, Suite J-2
Orem, UT 84058
**Phone:** (801) 885-7624
**Website:** www.nowican.org
**Purpose:** The mission at Now I Can is to help children with disabilities reach their full potential and greatest independence. They offer sessions of intensive suite therapy, cage strengthening, and physical therapy and massage.

## PARENTS FOR CHOICES IN EDUCATION

**Address:** 8 East Broadway, Suite 730
Salt Lake City, UT 84111
**Phone:** (801) 557-6507
**Website:** www.choiceineducation.org
**Purpose:** They offer and provide information on the Carson Smith Special Needs Scholarship.

## PCMC REHABILITATION MAIN CAMPUS

**Address:** 100 North Medical Drive
Salt Lake City, UT 84113
**Phone:** (801) 588-3950 – Audiology
(801) 588-3740 – Inpatient
(801) 588-3969- Physician
**Purpose:** All sites offer diagnostic testing and treatment for children. They serve children with: injuries and illness; physical challenges; speech, language, and cognitive delays; developmental delays; hearing loss; and other conditions that affect the daily activities most children enjoy. Each therapy program is planned to meet the unique needs of each child.

## PHOENIX SERVICES CORPORATION

**Address:** 220 East 3900 South, Suite 2
Murray, UT 84107
**Phone:** (801) 263-3865
**Toll-free:** (866) 363-5009
**Purpose:** They provide child and family services including summer program, respite, family, support, and educational supports.

## PEOPLE FIRST OF UTAH

**Address:** 155 South 300 West, Suite 100
Salt Lake City, UT 84101
**Phone:** (801) 533-3965
**Toll-free:** (800) 323-8824
**Website:** www.gcpd.org
**Purpose:** People First is a self advocacy organization for adults with disabilities under Governor's Council for People with Disabilities. There are over 20 groups located throughout Utah that have monthly educational meetings. Contact the number above for the group in your area.

## PRADER-WILLI SYNDROME ASSOCIATION SUPPORT GROUP

**Contact:** Lisa Thornton
**Phone:** (801) 582-0998
**Website:** www.pwsausa.org/UT
The mission of the Utah Prader-Willi Association is to provide families and professionals with a network of support, resources and information, to promote awareness of the syndrome and raise funds that will directly benefit Utahan's with PWS. In addition, the association facilitates opportunities to congregate pro-active individuals who can pool talents, resources, ingenuity and vision to produce more options, increase quality of life, and create a brighter future for individuals with PWS.

## PRIMARY CHILDREN'S MEDICAL CENTER (PCMC)

**Address:** 100 North Medical Drive
Salt Lake City, UT 84113
**Phone:** (801) 588-3934 (operator)
**Purpose:** The mission of PCMC is to provide quality and comprehensive pediatric medical services.

## PROJECT GAIN

**Address:** 250 E. 1850 South
Salt Lake City, UT 84112
**Phone:** (801) 581-8754
**Website:** www.accessgolf.org
**Purpose:** Project GAIN (Golf: Accessible and Inclusive Networks) Golf professionals, rehabilitation specialists, recreation professionals as well as volunteers and mentors implement a rigorous program of golf instruction and social development for a wide variety of people with disabilties. Project GAIN organizes and conducts community based programs that introduce people with disabilities to the game of golf.

## PTA, PARENT TEACHER ASSOCIATION, *SEE UTAH CONGRESS OF PARENT TEACHER ASSOCIATION*

## REHABILITATION SERVICES, DIVISION OF

**Address:** Utah State Office of Rehabilitation
250 East 500 South
Salt Lake City, UT 84111-3204
**Phone:** (801) 538-7530
**Purpose:** Provides vocational rehabilitation services for individuals with a disability to bring about gainful employment.

## RELAY UTAH - 711

**Phone:** 711
**Toll-free:** (800)676-3777 (Customer Service)
**Toll-free:** (800) 346-4128 (TTY)
**Toll-free:** (888) 735-5906 (Voice)
**Website:** www.relayutah.gov
**Purpose:** The Relay Utah service was initiated in 1988 as one of the first Relay services established in the United States. Housed under the umbrella of the Public Service Commission, Relay Utah provides access to hearing assistive equipment and telephone relay services, through Sprint, to allow Utah citizens who are deaf, hard of hearing or speech disabled more efficient communication.

## RISE, INC.

**Address:** 1561 North Grandview Lane
Provo, UT 84604
**Phone:** (801) 373-1197 **Salt Lake County:** (801) 363-3300
**Toll-free:** (800) 257-9920
**Website:** www.acumentfiscalagent.com/RIS/index.asp
**Purpose:** RISE, Inc. is a not for profit organization that provides supports to people with disabilities and their families. RISE, Inc. has been in operation since 1987 providing services in Utah, Arizona, Kansas, Wisconsin, Oregon, and Washington. The agencies initial mission was to develop a model of supports that would meet the needs of children with disabilities in their most natural setting, the family. This model, titled "The Professional Parent Program," offers children an alternative to institutionalization when their biological family cannot meet their needs at home. The Professional Parent model is the hallmark service of RISE, INC.

## SALT LAKE ADVOCACY AND COMMUNITY TRAINNG (SL ACT)

**Address:** 2595 E. 330 South #360
Salt Lake City, UT 84109
**Phone:** (801) 412-3798
**Purpose:** Advocacy and training for people with developmental disabilties in Salt Lake County.

## SALT LAKE COUNTY PARKS AND RECREATION – ADAPTIVE RECREATION

**Address:** 8446 S. Harrison St.
Midvale, UT 84047
**Phone:** (801) 561-0075
**Website:** http://www.parks-recreation.org/
www.activityreg.org
**Purpose:** Salt Lake County Parks and Recreation Adaptive Program offers a variety of programs and activies for people with disabiltiies ages 5 years though adulthood. The Mission of the adaptive program is to enhance the quality of life for individuals with challenges by facilitating an appropriate leisure life-style through positive recreation and education experiences regardless of sex, race, creed, or ability. Programs include socialization activities, various sports, and summer day camps.

## SELF DETERMINATION, INC.

**Address:** 2225 East Murray-Holladay Road, #106
Holladay, UT 84117
**Phone:** (801) 274-6058
**Purpose:** Assist adults with mild to moderate intellectual disabilities with independent living skills and employment support. Open to adults age 18 and older who are capable of being independent with minimal but consistent support from staff and family.

## SHRINER'S HOSPITAL FOR CHILDREN -- INTERMOUNTAIN

**Address:** Fairfax Road at Virginia Street
Salt Lake City, UT 84103-4399
**Phone:** (801) 536-3500
**Website:** http://www.shrinershq.org/shc/intermountain/index.html
**Purpose:** The Intermountain Shriners Hospital is a 40-bed pediatric orthopaedic hospital providing comprehensive orthopaedic care to children at no charge. The hospital is one of 22 Shriners Hospitals throughout North America. The Intermountain Hospital accepts and treats children with routine and complex orthopaedic problems, utilizing the latest treatments and technology available in pediatric orthopaedics, resulting in early ambulation and reduced length of stay.

## SNAPSS – SPECIAL NEEDS ASSOCIATION OF PARENT SUPPORT SYSTEMS

**Address:** Mikael Stansfield
990 Bel Mar Drive
Ogden, UT 84403
**Phone:** (801) 334-6867
**Purpose:** Services offered include:

- Statewide directory of families of children with special needs (networking with other families)
- Local activities and support groups

## SOCIAL SECURITY ADMINISTRATION (SSA)

**Address:** 202 West 400 South
Salt Lake City, UT 84101
**Phone:** (801) 524-4115
**Website:** www.ssa.gov
**Purpose:** Social Security Disability/SSI. Their mission is to advance the economic security of the nation's people through compassionate and vigilant leadership in shaping and managing America's Social Security programs.

## SOUTH DAVIS COMMUNITY HOSPITAL – *PEDIATRIC HOME HEALTH AND HOSPICE*

**Address:** 401 South 400 East
Bountiful, UT 84010
**Phone:** (801) 298-8983
**Website:** www.sdch.com
**Purpose:** South Davis Home Health and Hospice, an agency of South Davis Community Hospital, is committed to offering pediatric patients quality care provided by highly trained health care professionals.

## SOUTH VALLEY SCHOOL (JORDAN SCHOOL DISTRICT)

**Address:** 8400 South 1700 West
West Jordan, UT 84088
**Phone:** (801) 565-7592
**Website:** http://web.jordan.k12.ut.us/svs
**Purpose:** South Valley School is a public school program providing special education, vocational and community-based training to students ages 16 - 22 with disabilities in the Jordan School District.

## SOVEREIGN FINANCIAL

**Address:** 455 East 500 South, #400
Salt Lake City, UT 84111
**Phone:** (801) 484-6645
**Purpose:** Sovereign Financial provides legal and financial solutions for families concerned with special needs trusts and caretaker trusts.

## SPECIAL OLYMPICS UTAH

**Address:** 4 Triad Center, Suite 105
Salt Lake City, UT 84180
**Phone:** (801) 363-1111
**Toll-free:** (800) 722-1589
**Website:** www.sout.org
**Purpose:** Special Olympics is an international program of year-round sports training and athletic competition for more than one million children and adults with mental retardation. Special Olympics Utah, a chapter of Special Olympics, was founded in 1969 and serves more than 2,000 athletes statewide.

## SPECTRUM ACADEMY

**Address:** 837 West Foxboro Drive
North Salt Lake, UT 84054
**Mailing Address:**
P.O. Box 540691
North Salt Lake, UT 84054
**Website:** www.spectrumcharter.org
**Purpose:** The Spectrum Academy implements research-based teaching methods to educate children with Asperger's Syndrome, Autism, communication disorders, and sensory integration disorders.

## SPINA BIFIDA ASSOCIATION OF UTAH

**Address:** David Peterson – President
PO Box 97
Farmington, UT 84111-0097
**Phone:** (801) 295-6558
**Email:** dave@farmingtonut.com
**Nat'l Website:** www.sbaa.org
**Utah Website:** http://groups.yahoo.com/group/sbau
**Purpose:** The Mission of the Spina Bifida Association of America is to promote the prevention of spina bifida and to enhance the lives of all affected.

## SPLORE

**Address:** 880 East 3375 South
Salt Lake City, UT 84115
**Phone:** (801) 484-4128
**Website:** www.splore.org
**Purpose:** SPLORE provides day canoe and climbing trips in Salt Lake County during the summer, day and overnight ski trips in the Big Cottonwood Canyon and the surrounding areas in the winter and day to week long rafting trips in the Moab area May through October. They also provide some specialized annual trips.

## TALK TO ME – *SPEECH LANGUAGE AND COMMUNICATION THERAPY*

**Contact:** **Brenda Morgan**
**Address:** 115 South 1200 East
Lindon, UT 84042
**Phone:** (801) 785-4677
**Purpose:** Brenda at "Talk to Me" is dedicated to helping you and your child. She has special training in programs for children with Autism, Down syndrome, Articulation Disorders, and language disorders and in early intervention services.

## TEN THOUSAND VILLAGES

**Address:** 2186 Highland Drive
Salt Lake City, UT 84106
**Phone:** (801) 485-8827
**Website:** www.tenthousandvillages.com
**Purpose:** Since 1946 Ten Thousand Villages has supported the work of literally tens of thousands of artisans in over 30 countries in Asia, Africa, Latin America and the Middle East, making us one the largest fair trade organizations in North America. Working with more than 100 artisan groups, we purchase fine pieces from craftspeople with whom we have longstanding, nurturing relationships…helping to bring dignity to their lives.

## TOURETTE SYNDROME ASSOCIATION - UTAH

**Address:** PO Box 701312
West Valley City, UT 84170
**Toll-free:** (866) 274-0700
**Website:** www.tsa-usa.org
**Purpose:** Their mission is to identify the cause of, find the cure for and control the effects of this disorder. They develop and disseminate educational material to individuals, professionals, and to agencies in the fields of health care, education and government; coordinates support services to help people and their families cope with the problems that occur with TS; funds research that will ultimately find the cause of and cure for TS and, at the same time, lead to improved medications and treatments.

## TRI-COUNTY INDEPENDENT LIVING CENTER

**Address:** P.O. Box 428
2726 Washington Boulevard
Ogden, UT 84402
**Phone:** (801) 612-3215
**Toll-Free:** (866) 734-5678
**Purpose:** Their mission is to assist persons with disabilities in achieving greater independence by providing services and activities which enhance independent living skills and promote public understanding, accommodation, and acceptance of their rights, needs, and abilities.

## TURN COMMUNITY SERVICES

**Address:** 850 South Main Street
Salt Lake City, UT 84101
**Phone:** (801) 524-8618
**Website:** www.turn.nu
**Purpose:** TURN Community Services provides a variety of programs for individuals with developmental disabilities including; residential, supported employment, day training and diversion programs.

## UCARE

**Address:** 120 North 200 West
North Salt Lake, UT 84054
**Phone:** (801) 538-4608
**Website:** www.ucare.utah.gov
**Purpose:** UCARE provides help for caregivers, seniors, people with disabilities, human resource personnel, and medical professionals. They have a website that has been developed by the State of Utah, Department of Human Services. It was funded by the Centers for Medicare and Medicaid Services, Department of Health and Human Services. Their website will help you find answers to questions such as: What is long-term care? How do I choose a long-term care option? What resources are available in Utah and nationally?

## UNITED CEREBRAL PALSY

**Mailing Address:**
P.O. Box 65219
Salt Lake City, UT 84165
**Street Address:**
3550 South 700 West
West Valley City, UT 84119
**Phone:** (801) 266-1805
**Website:** www.ucputah.org
**Purpose:** To advance the independence, productivity and full citizenship of persons with disabilities.

## UREAD

**Address:** 12691 South 2580 West
Riverton, UT 84065
**Phone:** (801) 254-3332
**Purpose:** UREAD is a coalition of concerned parents and educators who are dedicated to addressing the needs of the children in Utah who have the learning difference of Dyslexia. It is only through a combined effort of every one of us that our mission and goals can be accomplished. Their mission is that they are dedicated to ensuring that every Utah student with the learning difference of Dyslexia will receive scientifically based instruction and services consistent with his/her needs.

## US AUTISM AND ASPERGERS ASSOCIATION, INC. (USAAA)

**Address:** P.O. Box 532
Draper, UT 84020-0532
**Phone:** (801) 649-5752
**Website:** www.usautism.org
**Purpose:** USAAA's mission is to enhance the quality of life of individuals and their families/caregivers touched by autism spectrum disorders by providing educational and family support through conferences/seminars, and published and electronic mediums. USAAA distributes information with regard to biomedical treatments/adjunct therapies, and research to parents, practitioners, students, and teachers who are associated with the autism and Asperger's Syndrome communities.

## USBORNE CHILDREN'S BOOKS

**Phone:** (801) 426-9923
**Website:** www.ubah.com/k0567
**Purpose:** An incredible line of children's books is available!

## UTAH ADAPTIVE RECREATION NETWORK (UARN)

**Address:** Alex Johnson
880 East 3375 South
Salt Lake City, UT 84106
**Phone:** (801) 484-4128
**Website:** www.splore.org
**Purpose:** Utah Adaptive Recreation Network is a collaborative body of six different organizations in Utah that provide recreational opportunities for children and adults with disabilities and special needs. UARN is a coordinated effort of: National Ability Center, SPLORE, Common Ground, Project Gain, Camp K, and Salt Lake Parks and Recreation. They are trying to raise awareness of recreational programs available to people with disabilities and their families.

| | | |
|---|---|---|
| **Common Ground**<br>Phone: (435) 713-0288<br>290 N. 400 East<br>Logan, UT 84321<br>www.cgadventures.org | **Kostopulos Dream Foundation**<br>Phone: (801) 582-0700<br>2500 Emigration Canyon<br>Salt Lake City, UT 84108<br>www.campk.org | **National Ability Center**<br>Phone: (435) 649-3991<br>PO Box 682799<br>Park City, UT 84068<br>www.NAC1985.org |
| **Project Gain**<br>Phone: (801) 581-8754<br>250 E. 1850 South Room 200<br>Salt lake City, UT 84112<br>www.accessgolf.org | **Salt Lake Parks & Recreation**<br>Phone: (801) 561-0075<br>2001 S. Sate Suite S4400<br>Salt Lake City, UT 84109<br>www.parks-recreation.org | **SPLORE**<br>Phone: (801) 484-4128<br>880 E. 3375 South<br>Salt Lake City, UT 84106<br>www.splore.org |

## UTAH AUTISM RESEARCH PROJECT

**Address:** 421 Wakara Way #143
Salt Lake City, UT 84108
**Phone:** (801) 585-9098
**Website:** utahautismresearchproram.genetics.utah.edu
**Purpose:** The Utah Autism Research Program conducts research into various possible causes of autism spectrum disorders. Some of their current projects include: genetic studies utilizing the unique genealogical resources available in Utah and studies of the immune system in autism. This research is critical to our understanding of the causes and, ultimately, the successful treatments for autism spectrum disorders.

## UTAH AUTISM FOUNDATION

**Website:** http://www.utahautismfoundation.org/
**Purpose:** The Utah Autism Foundation is a nonprofit organization formed to identify and support research on both a local and national level into the cause, prevention, and potential treatment of autism.

## UTAH ASSISTIVE TECHNOLOGY FOUNDATION

**Address;** 6835 Old Main Hill
Logan, UT 84322-6835
**Toll-free:** (800)524-5152
**Website:** www.uatf.org
**Purpose:** A non-profit organization that helps individuals with disabilities live more productive and independent lives by providing zero and low interest loans to purchase assistive technology devices and services.

## UTAH CENTER FOR ASSISTIVE TECHNOLOGY (UCAT)

**Address:** 1595 West 500 South
Salt Lake City, UT 84104
**Phone:** (801) 887-9500
**Website:** www.usor.state.ut.us/ucat
**Purpose:** UCAT is a state government agency that provides assistive technology services to anyone in Utah. They help people with disabilities and their caregivers select, acquire, and learn to use assistive technology devices that can help them cope with the functional limitations caused by their disaiblities.

## UTAH CONGRESS OF PARENTS AND TEACHERS ASSOCIATION (PTA)

**Address:** 5192 South Greenpine Drive
Salt Lake City, UT 84123
**Phone:** (801) 261-3100
**Toll-free:** (866) PTA UTAH
**Website:** www.utahpta.org
**Purpose:** The Utah PTA will help every child reach full potential and will: *Advocate:* Support and speak on behalf of children and youth; *Involve:* Encourage positive involvement in all facets of a child's life; *Develop:* Assist in developing skills to raise and protect children and youth.

## UTAH DEVELOPMENTAL DISABILITIES COUNCIL

**Address:** 155 South 300 West, Suite 100
Salt Lake City, UT 84101
**Phone:** (801) 533-3965
**Toll-free:** (800) 333-8824
**Website:** www.gcpd.org
**Purpose:** The mission of the Utah DD council is to be the states leading source of critical innovative and progressive knowledge, advocacy, leadership and collaboration to enhance the life of individuals with developmental disabilities.

***Notes***

## UTAH DOWN SYNDROME FOUNDATION (UDSF)

**Address:** PO Box 753
Farmington, UT 84025-0753
**Toll-free:** (877) 499-UDSF (8373)
**Website:** www.udsf.org
**Purpose:** The UDSF's purpose is to: provide support, training, counseling and education for individuals with Down syndrome, their parents and families and networking with the community. To receive a free subscription to the bi-monthly newsletter, The Advocate or a Newborn Information Booklet, please contact them. There are annual Down syndrome awareness activities statewide. There are 14 local chapters across the state. ***Find your local chapter in the chart below.***

| | | | |
|---|---|---|---|
| **Cache Valley**<br>Dorene Rendon<br>(435) 750-6549 | **Box Elder**<br>Wendy Lowry<br>(435) 734-9129 | **Davis County**<br>Leona Cooper<br>(801) 299-1543 | **Garfield County**<br>Tracy Johnson<br>(435) 679-8824 |
| **Kane County**<br>Julie Brown<br>(435) 644-2461 | **Monticello**<br>Marilee Bailey<br>(435) 587-2313 | **Ogden**<br>Anita South<br>(801) 731-1236 | **Salt Lake**<br>Lisa Kingsbury<br>(801) 576-9158 |
| **Sanpete County**<br>Sidney Armstrong<br>(435) 283-4580 | **St. George**<br>Lindy Thompson<br>(435) 688-1444 | **Utah County**<br>Cathy Collard<br>(801) 768-8625 | **Vernal**<br>Marion Lance<br>(435) 781-1148 |
| **Wasatch/Summit County**<br>Natalie Clyde<br>(435) 654-3293 | **Wayne, Sevier, Piute County**<br>Tasha Birch<br>(435) 836-2113 | *Another Great Resource:*<br>**Down Syndrome Clinic at PCMC**<br>(80)588-2712 | |

## UTAH FAMILY PARTNERSHIP NETWORK

**Address:** 2500 South State Street, Room D120
Salt Lake City, UT 84115
**Phone:** (801) 646-4155
**Website:** www.ufpn.org
**Purpose:** The goal of the Utah Family Center is to strengthen partnerships among family, school and community to address the whole child. Local Utah Family Centers act as central connecting points in their local communities. The Centers advocate for families, support and build upon the strength of all families and children, and provide opportunities where an individual can more fully contribute to his family, school, community and global society.

## UTAH FAMILY VOICES – HEALTH INFORMATION, EDUCATION AND SUPPORT

**Phone:** (801) 584-8236
**Toll-free:** (800) 829-8200 ext. 8236
**Website:** www.familyvoices.org
**Purpose:** Family Voices is a national grassroots network that addresses issues concerning the health care of children with special needs. They provide information and education, share the expertise and experience of families with state and national policymakers, the media, health professionals and other families. They also work collaboratively with state agencies, parent support and advocacy groups as well as with health care providers and hospitals.

## UTAH HOME EDUCATION ASSOCIATION

**Address:** PO Box 737
Farmington, UT 84025
**Phone:** See the website for telephone contacts in your area.
**Website:** www.uhea.org
**Purpose:** The Utah Home Education Association has been established to support the education of children in the home as a viable alternative to the existing public and private educational system. Please visit their website for contacts in your area.

## UTAH INDEPENDENT LIVING CENTER, INC.

**Address:** 3445 South Main Street
Salt Lake City, UT 84115-4453
**Phone:** (801) 466-5565(Voice)
(801) 466-9910 (TTY)
(435)843-7353 – Tooele Outreach Branch
**Purpose:** To assist persons with disabilities in achieving greater independence by providing services and activities which enhance independent living skills and promote the public understanding, accommodation, and acceptance of their rights, needs and abilities.

## UTAH MEDICAL HOME INTEGRATED SERVICES PROJECT

*A Project of Children with Special Health Care Needs*

**Address:** PO Box 144610
Salt Lake City, UT 84114-4610
**Phone:** (801) 584-8584
**Toll-free:** (800)829-8200
**Website:** www. Medhomeportal.org
**Purpose:** The Utah Collaborative Medical Home Project at the Children with Special Health Care Needs provides technical support to physicians across Utah to become medical homes for chronically ill and disabled children. A medical home is a family-centered approach to providing health care by professionals, parents, and allied health care workers acting as partners to identify and access all the medical and non-medical services needed for children to reach their potential. For more information call or visit the website.

## UTAH PARENT CENTER

**Address:** 2290 East 4500 South, Suite 110
Salt Lake City, UT 84117-4428
**Phone:** (801) 272-1051
**Toll-free**: (800) 468-1160
**Website:** www.utahparentcenter.org
**Purpose:** The Utah Parent Center (UPC) is a statewide non-profit organization founded in 1984 to provide training, information, referral, and assistance to parents of children and youth with ALL disabilities: physical, mental, learning and emotional. Staff at the Center are primarily parents of children and youth with disabilities who carry out the philosophy of PARENTS HELPING PARENTS

## UTAH SCHOOL NURSES ASSOCIATION

**Phone:** (801) 703-3369
**Website:** www.utsna.org
**Purpose:** "The mission of the Utah School Nurses Association is to protect and improve the health and safety of children and families by supporting comprehensive school health nursing services. These programs provide prevention, detection and resolution of health concerns, thereby improving educational achievement and enhancing the quality of life."

## UTAH SCHOOLS FOR THE DEAF AND THE BLIND

**Address:** 742 Harrison Boulevard
Ogden, UT 84404-5298
**Phone:** (801) 629-4700 (Voice)
**Phone:** (801) 629-4701 (TTY)
**Toll-free:** (800) 990-9328
**Website:** www.usdb.org
**Purpose:** Their purpose is to provide consultation, resources, and direct education services to children from birth through age 21 with hearing and/or visual impairments and their families. Family support specialists can be contacted through the main number listed above.

## UTAH STATE OFFICE OF EDUCATION

**Address:** 250 East 500 South
PO Box 144200
Salt Lake City, UT 84111-4200
**Phone:** (801) 538-7500
**Website:** www.usoe.k12.ut.us

## UTAH WORK INCENTIVE INITIATIVE & WORKABILITY

**Address:** 1595 West 500 South
Salt Lake City, UT 84104
**Phone:** (801) 887-9387
**Purpose:** The overall goal of the Utah Work Incentives Initiative (UWIN) project is to create a comprehensive, consumer-responsive system of work supports that will increase employment outcomes for individuals with disabilities in Utah.

## WORKABILITY

***SEE ABOVE: UTAH WORK INCENTIVE INITIATIVE & WORKABILITY***

## WORK, INC.

**Mailing Address:**
PO Box 571
Provo, UT, 84603
**Phone**: (801) 262-0950 – Salt Lake County
**Phone:** (801) 812-0222 - Utah County
**Purpose:** To provide supported employment services for people with disabilities. Work, Inc. has locations in both Provo and Salt Lake counties.

## NOTES:

**Utah Parent Center**
2290 East 4500 South, Suite 110
Salt Lake City, UT 84117-4428
(801) 272 – 1051
(800) 468 – 1160
www.utahparentcenter.org
upcinfo@utahparentcenter.org